Thursday, 28 November 2024

(10.00 am)

CLOSING SUBMISSIONS (continued)

MS CAREY: My Lady, good morning. For the final session of Module 3, can I invite firstly Ms Morris King's Counsel to address you.

LADY HALLETT: Thank you very much, Ms Carey.

Ms Morris.

Closing statement on behalf of the Royal College of Nursing

by MS MORRIS KC

MS MORRIS: I represent the Royal College of Nursing. These submissions will focus on our recommendations that we seek. You've already heard the profoundly affecting evidence of Rose Gallagher and Patricia Temple.

First of all, recommendations in relation to workforce. There needs to be a suitably resourced, educated and trained healthcare workforce in place so that it can respond to the next challenge at speed.

Staffing levels need to be based on workforce projections that reflect actual population need with safety-critical nurse to patient ratios enshrined in law. Without an adequate number of medical, clinical and healthcare workers with the right mixture of skills and who are able to deliver the appropriate standard of patient care to meet the demand of the country at the

present time, in the absence of a pandemic, then there is a poor prospect of the demand created by a future pandemic being met.

Secondly, partnership with the nursing profession.

During the pandemic, a vital opportunity was missed by the government and its agencies to recognise the value of the contribution that the Royal College of Nursing could have made to its access to clinical expertise and strategic oversight on nursing issues which impact on the delivery of health and care services, especially to the most vulnerable.

Full and proper engagement through partnership working with the nursing profession, particularly on infection prevention and control national guidance, from the formative stages through to implementation and monitoring, is needed to ensure that guidance is robust, fully informed, evidence-based and effectively implemented.

There must also be professional nursing representation equivalent to medical representation at briefings, meetings, and so on, regardless of whether these are led by the Chief Medical Officer or other health leaders.

There should also be transparent governance and visibility of cells and response teams so that the

nursing profession may fully understand what lies behind incidence response mechanisms and risk management.

Turning in particular to infection prevention and control. There should be input from non-IPC specialists, when producing future IPC guidance, including health and safety experts, occupational hygienists, aerosol scientists, occupational health and wider professional stakeholders, such as paramedics, speech and language therapists, whose roles align with nursing care.

This holistic approach avoids groupthink, ensures that IPC guidance is workable, and provides an opportunity for specialisms to raise concerns at an early stage before guidance is finalised and published.

This is a key lesson which should be implemented in the development and production of future guidance. Had it been in place during the pandemic, concerns over the applicability of such guidance could have been addressed prior to publication.

Furthermore, the team responsible for issuing and updating the interim IPC guidance should form, now, a post-pandemic group to undertake a wide stakeholder debrief on the lessons identified and implement recommendations based on this.

PPE.

The government must adopt a longer-term approach to sustainably procuring and maintaining stockpiles of PPE, as well as other medical equipment essential for staff and patient safety. All governments and employers in the UK must ensure that all nursing staff, regardless of practice setting, geographical location, role, employer or finances, have access to that which is necessary to use when required.

There should be funding for the development of reusable respiratory PPE that is acceptable to staff and patients, and there should be greater transparency and governance of the procurement process.

Working conditions and monitoring to inform the future.

There needs to be comprehensive data collection, and systemic reporting on deaths, infection rates, and self-isolation rates for nursing staff, and that should capture ethnicity and gender. It's necessary in order accurately to scrutinise the impact of infection prevention and control measures in real time and it should apply to all care sectors and not just hospitals.

There needs to be proper management and support for the health and well-being of nursing staff. It includes enabling staff to take breaks, annual leave,

and the review and control of working patterns to prevent long shifts and access hours being worked. We invite a particular recommendation that all employers make available and fund timely access to confidential counselling and psychological support.

Within this context, the needs and perceptions of ethnic minority nursing staff should be fully explored and addressed within pandemic learning.

Finally, Long Covid. There must be effective self-management and support in the community for those with Long Covid. It's vital that the findings of research into Long Covid amongst health and social care staff inform workforce planning needs. Support for these staff members needs to continue and the impact of Long Covid in terms of increased long-term absence needs to be factored into workforce planning.

The UK Government must classify Covid-19 as an occupational disease, and afford healthcare professionals better support through policies, guidance and occupational health provision.

In addition, the Royal College of Nursing calls for a key worker compensation scheme to provide financial support to healthcare professionals suffering from Long Covid.

That concludes my submissions.

LADY HALLETT: Sorry, I was a bit slow unmuting. Thank you very much indeed, Ms Morris.

Ms Clarke.

Closing statement on behalf of Royal College of Anaesthetists, The Faculty of Intensive Care Medicine and The Association of Anaesthetists by MS CLARKE

MS CLARKE: Thank you, my Lady.

I appear on behalf of the Royal College of Anaesthetists, the Faculty of Intensive Care Medicine, and The Association of Anaesthetists.

We wish to start by thanking the Inquiry for its ongoing work, reiterating that our thoughts remain with all of those impacted by Covid-19 and acknowledging the concerning inequalities of outcomes raised by the other witnesses in this Inquiry.

We also wish to pay tribute to the skills, dedication and immense personal sacrifices made by our members during the pandemic. Without their work and that of the wider healthcare teams, the impacts of Covid-19 on the nation would have been considerably worse and many more lives would have been lost.

Our members worked to treat patients in the most stressful conditions, taking its toll on their mental and physical health, and exposed them to unusual levels of moral distress. Those in training provided crucial

clinical services in the face of disruptions to their own training, qualifications and development. The contributions and sacrifices must be acknowledged and, we say, applauded.

In this closing statement we will reinforce some of our key points made in earlier evidence, add additional context regarding decisions about admission to intensive care, and reiterate our suggestions for recommendations to support planning for any future pandemic or crisis.

Firstly, staffing and capacity. ICUs are where the most critically-ill patients are treated and supported in hospital, and data from the Intensive Care National Audit & Research Centre shows that during the pandemic around 400,000 patients were treated in ICUs, including around 50,000 of the very sickest Covid-19 patients.

We wish to reinforce how precarious capacity in intensive care was prior to the pandemic. As early as 2018, the bed fill rate in ICUs had almost reached recommended safe limits in Scotland and was already surpassing it in England, Wales and Northern Ireland.

The emergence of Covid-19 resulted in the requirement for Herculean efforts to expand capacity, demanding extensive physical remodelling and

inventiveness.

Efforts included shutting down other hospital services, converting non-ICU spaces into ICUs, and sourcing or repurposing essential equipment like ventilators to fill these spaces. This had significant consequences for waiting lists which continue to impact on patients to this day.

Expanding capacity also required cancellation of leave, reduced staff-to-patient ratios, the curtailment of normal educational opportunities, and redeploying staff, often to act outside of their normal skill set.

While ICU capacity was increased with staffed beds rising from around 4,100 to over 6,000 in England, this came at considerable cost. It is important to acknowledge that was also achieved unequally between nations and within English regions with expansion rates ranging from 45% in Yorkshire and Humber to 100% in the north-east.

This may reflect the known unequal provision of ICU beds across England prior to the pandemic.

Unfortunately, following the pandemic, ICU capacity has not improved in a uniform way, and this potentially adds to pre-existing health inequalities.

The role of anaesthetists is also vital. They are central to surgery, they can lead enhanced perioperative

care services and offer critical support in maternity care.

In early 2020, the shortfall of anaesthetists across the UK had reached 1400. Anaesthetic workforce shortages were a key factor behind the steadily growing surgical waiting list in preceding years and these significantly increased when anaesthetists were redeployed to bolster ICU capacity during the pandemic. This impacted other services that rely on anaesthetists, particularly maternity services, where there is a constant needs need for their expertise. The shortfall of anaesthetists now stands at 1900. This limits the rate at which the NHS can perform operations and risks a repeat of untenable waiting list increases, were another crisis to occur.

We therefore emphasise to the Inquiry the importance of investment in the anaesthetic workforce in order to provide reserve capacity for ICU to address the post-pandemic backlogs, and to ensure women have timely access to the full range of anaesthesia services that they might need during childbirth.

Turning now to admission to intensive care. We note that the Inquiry has paid particular attention to ICU admission decisions and the lack of guidance for how clinicians should act if demand for ICU exceeds supply.

This was an issue to of concern for some of our members during the first wave the pandemic.

It is important to acknowledge that before, during and after the pandemic, ICU admission decisions are made on a patient's condition, the trajectory of the condition, its treatability and any wishes they may have declared. A judgment is made about whether the patient needs and would benefit from ICU treatment, or whether other forms of care are more appropriate.

This fundamental decision-making process remained in place throughout the pandemic. However, in the first wave, clinicians were forced to make decisions, knowing little about Covid-19 or how intensive care treatments would affect its progression, meaning the benefits of ICU treatment could not be effectively balanced against the potential burdens. As the pandemic progressed, knowledge developed rapidly and by the second wave decision-making was more informed.

During the pandemic there was also a need to shift exploration of the appropriateness of ICU treatment to earlier in the admission pathway. Prior to Covid-19 these discussions would usually be held by the intensive care team at the point of referral, however, during the pandemic intensive care staff were so stretched that ward-based teams were required to take on a greater role

than usual in these discussions. To facilitate this, the NICE guideline NG159 and an accompanying toolkit of resources was produced.

One concern held by some of our members, particularly during the first wave, is that situations may have arisen where the number of patients needing ICU treatment may exceed capacity. Such eventualities could not be ruled out and we believe they should have been planned for.

FICM advocated for the statement related to such planning during the development of NICE guideline NG159, and despite such efforts did not have final sign-off on the guidance and ultimately references to such situations were not included.

We were also of the view that if any guidance was produced for such situations, it needed to be from a national statutory body such as NICE and have applicability across all four nations, with wide support from the medical profession and the public. This was for many reasons, including giving reassurance to doctors concerned about legal challenge to their decisions, ensuring consistent nationwide advice, and maintaining patient and public confidence through transparent and consistent decision-making.

Turning now to recommendations.

In light of our members' collective experiences prior to and during the pandemic, to aid preparedness for any future crisis, we would like to take this opportunity to highlight a number of points for consideration.

We propose that baseline intensive care capacity should be expanded. This must be supported by a clear methodology for measuring bed occupancy and workload strain across individual units. It also requires investment in beds, infrastructure, PPE, equipment, and, most importantly, staffing.

We also propose that more training places are funded to boost the number of intensivists and anaesthetists, to ensure that the NHS can meet both current and future demands.

The alarming bottleneck in the medical training system between foundation training and speciality training needs to be addressed.

Last year across the UK around 20,000 foundation-level doctors applied for just 8,000 speciality training places, leaving 12,000 unable to progress. At a time when the NHS is in desperate need for more doctors, this bottleneck must be urgently addressed.

While some efforts have been taken to boost

staffing levels, including a one-off allocation of 114 extra ICU training places since 2020, and also an increase of 70 extra higher anaesthetic places in 2020 recurring for the following two years, going forward increases like this must be made permanent and built upon, as need is far higher.

In anaesthesia, the training system could accommodate at least 59 extra core training places and 81 higher training places per year over and above the current allocation.

FICM and the Intensive Care Society have also developed clear staffing standards in the guidelines for the provision of intensive care services and we urge the Inquiry to recommend that all UK ICUs are adequately supported to meet these standards.

Finally, improved pandemic planning and preparation, should be established across the healthcare system with clear frameworks to facilitate stakeholder collaboration during future surges. We recommend this should include the creation of a framework to develop such guidance rapidly for any future pandemic where demand for ICU treatment may exceed supply. This framework should focus on identifying the necessary stakeholders to develop such guidance with a defined process for collaboration.

And in conclusion, we would like to thank the Inquiry for including our organisations as core participants in Module 3 and we offer our support in the development of the Inquiry's report and the implementation of its recommendations.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Clarke, very helpful.

Mr Jory.

Closing statement on behalf of Independent Ambulance Association by MR JORY KC

MR JORY: As my Lady knows, I make submissions on behalf of the Independent Ambulance Association.

The detail of our fuller submissions will be set out in our written document, but I'll get straight to the point here. We respectfully suggest six primary recommendations for your consideration.

One, we need a national NHS protocol for engaging independent sector ambulance services. Such a protocol would include, for example, an approved list of independent ambulance providers. It would ensure that any independent providers are properly and thoroughly regulated, that there is reliable quality control, that there are established terms of engagement, and that there is provision for contingency planning to address

emergency and surge demand.

During the pandemic, the IAA pivoted from their usual non-emergency role to help the NHS with 999 and emergency roles. One independent provider was testing up to 250 patients a day. Why is this protocol needed? In fact a number of witnesses speak to it, but I need only remind the Inquiry that when the former Secretary of State for Health and Social Care, Sir Sajid Javid was asked directly in this Inquiry whether such a national protocol would be helpful, he responded simply, but categorically, with the one word "yes".

The IAA and its chair, Alan Howson, stand ready to assist with developing this protocol.

Two, a permanent national team with oversight of non-emergency patient transport services should be established to manage this service. This team should be comprised of representatives from the NHS and the independent sector. Why? There are approximately 11 to 12 million individual non-emergency patient journeys undertaken each year, covering 140 million patient miles at a cost in excess of £500 million. Half of these journeys are carried out by the independent sector. The scale of this service cannot be run on the hoof, it needs structure, and organisation, and co-ordination,

especially when emergency demand diverts resources.

Of course when the pandemic hit, the pandemic had to take priority over the non-emergency sector, which impacted services for those who were seriously hurt or unwell; those, for example, who needed treatments like dialysis or cancer visits and services; transport of the elderly and the infirm; and others requiring assistance with travel due to disability or for other reasons. Resources were diverted from non-emergency to emergency services, and we may never know the true cost of diverting resources on such a scale. Surely we will want to avoid a simple tradeoff between the two in the future.

When the suggestion of such a team was put directly to the former Secretary of State, he agreed that it would "make sense".

Three. Key worker status must be granted on the basis of an individual's role, not the name of their employer. Frontline health workers from the independent sector should share the full benefits of key worker status enjoyed by NHS staff. The virus doesn't discriminate between employers. All frontline health workers should have equal access to PPE, testing, and other priorities to make their job easier to do and safer for them to carry out.

I mention here just two witnesses who have spoken to this point, Professor Philip Banfield who, when cross-examined by learned Stephen Simblet King's Counsel, agreed with the proposition that all healthcare workers should have been provided with respiratory protective equipment during the pandemic.

And when Jeane Freeman, Cabinet Secretary for Health and Sport in Scotland until May 2021 was asked whether she agreed that in any future pandemic anyone working as a frontline health worker, whether employed by the NHS or otherwise, should be provided with the same access to testing, and PPE, she immediately and unequivocally responded "yes".

Four. Any future guidance regarding health risks, whether from the government, or the health service should include guidance specific to the ambulance sector, and must involve consultation with the independent ambulance sector.

Many witnesses have spoken and agreed with this essential proposition and, again, we will set out the detail of the evidence in our closing written submissions.

Tracy Nicholls, chief executive of the College of Paramedics spoke of the lack of clear guidance to paramedics from the IPC and a lack of common sense in

the guidance. She wasn't just disappointed; she expressed what she called her "horror" of how inappropriate the guidance was for her members, which was unbending even after she made representations regarding the particular challenges faced by paramedics and other ambulance workers.

Such was the inadequacy of the guidance, that she said her members felt like cannon fodder, canaries in a coal mine. There appears to be a fundamental inability to understand the demands and unique working environment in which paramedics work.

When asked whether the ambulance sector should be consulted regarding future guidance, the former Secretary of State Matt Hancock said "of course", and went on to say that all on the ground should be.

Five. The supply of oxygen and other medical gases needs to be made secure and reliable.

We've heard evidence from a number of sources about the national shortage of oxygen and other gases for medical use. The chief executive NHS England, Amanda Pritchard gave evidence of the lack of preparedness for a surge in demand for oxygen during the pandemic. The national oxygen infrastructure programme, established in March 2020 at the outset of the pandemic, was set up to address this particular issue, but it had

as its focus the NHS estate and its capacity.

During the pandemic there was a chronic national shortage of portable oxygen cylinders in particular. Independent ambulance providers had to desperately scrape around to find their own sources. Many witnesses have spoken to this issue but the evidence from Professor Summers highlights the problems of a limited and narrow supply base. She told us the main supplier, BOC, was unable to match the surge and demand of both cylinders and gases.

Sir Chris Wormald spoke of the background of unstable international supply chains.

The inability to source oxygen, and cylinders in particular, had an immediate and devastating impact, as it meant ambulances were often taken out of operation altogether. At one stage 20 new and otherwise fully operational ambulances sat idle for several weeks awaiting portable oxygen cylinders, and six recommissioned vehicles were unable to be used because, again, of a lack of new oxygen cylinders.

So we need to expand the supply chain, as there is an overreliance on one source as supplier.

Six. Finally, a simple but clear recognition of the role the independent sector played in the pandemic and plays generally.

Of course there needs to be recognition of a much wider cohort. The sentiment behind slogans such as "Protect the NHS" are admirable but ultimately it's people, not institutions, we need to protect. And if, as in our view we should, we're going to celebrate the contribution of health and emergency workers, let's celebrate all of them within the NHS and without. Let's remember that healthcare workers were five times more likely to die than individuals in other occupations, as Mr Stanton mentioned in his closing remarks.

But it goes further. Within the healthcare sector, ambulance workers, as an occupation, had the highest incidence of deaths per capita during the pandemic.

The NHS relies fundamentally upon the independent ambulance sector and, as with NHS workers, individuals within the independent sector suffered personally in carrying out their work and made huge sacrifices in order to keep other people safe and to do their job. Whatever one's overarching view of the national response, it would have been significantly worse without their commitment, involvement and goodwill. To mark their role is both the right thing to do, but will also assist in guiding preparation for any future emergency.

My Lady, these proposals, we believe, are largely

cost neutral. They are also supported by evidence provided to this Inquiry, either orally or in writing. They are all, we believe, relatively straightforward to implement, and if implemented they will all have a constructive and immediate practical effect.

Thank you, my Lady, and thank you to counsel and the solicitors to the Inquiry and all the staff here that have helped with the smooth running of the Inquiry all together. Those are our submissions.

LADY HALLETT: Thank you very much indeed.

Ms Gowman.

Closing statement on behalf of Covid-19 Bereaved Families for Justice Cymru by MS GOWMAN

MS GOWMAN: Thank you, my Lady. I act on behalf of Covid Bereaved Families for Justice Cymru.

The Cymru group is disappointed there has yet again been a failure by the Welsh Government to account for what went wrong in Wales. Whether this be the failure to complete comprehensive look-back exercises, a failure to provide key documents to the Inquiry or the failure of Welsh witnesses to meaningful reflect or show contrition, there has been a systemic failure in accountability.

The Welsh Government and NHS Wales' woeful approach to learning lessons is best demonstrated by its

failure to conduct a national lessons learned review. In stark contrast to the approach of the other UK nations the look-back exercises in Wales have been piecemeal, a patchwork of reviews carried out by different bodies without cohesion or focus, all of them superficial, none of them getting to the heart of what went wrong.

Some Welsh witnesses have staunchly stood by the lessons learned work done in Wales. Others, such as Baroness Morgan, suggest that the Welsh Government is simply waiting for the Inquiry to report first. While the Inquiry is certainly an important process, it is deeply concerning that the Welsh Government wouldn't want to understand for itself what went wrong, wouldn't want to armour up as soon as possible for the next pandemic.

The lax approach to learning lessons in Wales is also illustrated by the, at best, cursory exploration of nosocomial infection. Wales' national nosocomial programme purportedly was set up to investigate individual patient safety incidents of nosocomial Covid. The Welsh Government, through Judith Paget, gave no meaningful reassurance that all cases of nosocomial deaths had in fact been recorded as patient safety incidents. There has been no national oversight.

Further, Eluned Morgan, Judith Paget and her predecessor Andrew Goodall, were somewhat nonchalant as to the absence of a national investigation into cluster outbreaks in Wales. The failure at national level to look at the root clauses of cluster outbreaks we say represents a clear missed opportunity to identify patterns and potentially lifesaving interventions.

The Cymru group considers that the inadequacy of the Welsh Government's approach to lessons learned is compounded by its continued failure to open itself up to detailed scrutiny by the Inquiry. The Cymru group has long highlighted concerns that the Welsh Government cherry-picks the disclosure it sends to the Inquiry and this is followed through to Module 3.

When Vaughan Gething gave evidence last week he told the Inquiry that his discussions with the chief executives of the health boards, the CNO and the CMO were minuted, but for reasons that are not clear to the Cymru group, these minutes have not been disclosed to the Inquiry. This is unacceptable, a derogation of transparency.

The Cymru group considers that the oral evidence given to this module can be characterised by a reluctance in many quarters of the Welsh Government to give open accounts of what went wrong and why.

A feature of this Inquiry has been to highlight that the system in Wales is plagued by blurred lines of accountability, which, in turn, allows for finger pointing instead of answered questions and proactive action. Notwithstanding that the Welsh Government accepted in its opening statement to the Inquiry that responsibility ultimately rested with them, Welsh Government witnesses have repeatedly deflected responsibility and criticism by deferring to the operational arrangements of health boards who, in turn, appear to have been looking to a rudderless Welsh Government for clear guidance and national oversight which did not always materialise.

Whilst the Welsh Government and NHS Wales congratulate themselves for things that were done well, the Cymru group says that this is because they have not looked closely enough at what went wrong and there remains a wide gulf within which no one is willing to take responsibility in Wales.

Within its oral closing, the Welsh Government has teased a potential acceptance that not all decisions taken in Wales worked, noting vaguely that issues have emerged or crystallised in respect of NHS capacity, critical care capacity, availability and distribution of PPE, field hospitals, nosocomial transmissions, and

services available to treat Long Covid. But frustratingly, the Welsh Government elaborated no further and the group looks forward with intrigue and scepticism to receiving the detail within the written closing.

In terms of recommendations the Welsh Government suggests that less is more. With respect, given its poor track record for reflection and learning lessons to date, the Cymru group considers that for the Welsh Government, less would, in fact, just mean less, and there is clearly a need for a suite of substantive recommendations which go beyond the Welsh Government's current proposals if there is to be meaningful change in Wales.

I turn to some of the principal issues of concern for those I represent.

First, the infection prevention and control guidance simply did not address the risk posed by Covid, an airborne virus. The guidance was grounded in flawed scientific view that Covid was transmitted via droplet and contact, and demonstrated an erroneous and, quite frankly, dangerous lack of appreciation of the likelihood of aerosol transmission and the potential for asymptomatic transmission, and as a result, insufficient consideration was given to appropriate risk mitigation

measures.

In particular, there was insufficient consideration given to ventilation, beyond the opening of windows. What about UV lights? What about HEPA filters, low cost and portable?

Baroness Morgan flippantly joked that a HEPA filter had been her most disappointing Christmas present. For the Cymru group, HEPA filters were a valuable piece of equipment which could have reduced nosocomial transmission rates and potentially saved lives.

The IPC cell, though not a decision-making body, became a de facto decision-making body because their recommendations were not challenged. As a consequence, the fundamentally flawed IPC guidance was simply not adopted -- was simply adopted by all, including decision-makers in Wales, without question.

The Cymru group finds this particularly concerning given that Sir Frank Atherton and the Welsh Nosocomial Transmission Group took a completely different view on the science regarding transmission. For example, in evidence, Sir Frank suggested that it was understood by him from a fairly early stage that there was a continuum of droplets to small particles to tiny particles. Despite this, not once did Sir Frank, or the Nosocomial

Transmission Group, challenge the IPC guidance or even describe it as inadequate.

Further, Public Health Wales were represented on the IPC cell and, indeed, Dr Eleri Davies of Public Health Wales was the chair from the 31 March 2021. Now, we've not heard evidence from Dr Davies, nor was a Rule 9 request sent to her. However, what we do know is that no significant changes were made to the IPC guidance to address aerosol transmission following her appointment as chair. And this suggests, we say, that either Dr Davies agreed with Dr Ritchie's view on the mode of transmission contrary to the views of others in Wales, or she understood the part played by aerosol transmission but somehow concluded that the guidance was sufficient, despite the absence of sufficient measures to address the risk.

Was the lack of challenge indicative of the cultural problem in scientific advisory groups in the UK, where advice becomes mired in groupthink, or was it because the wrong people were making the decisions about IPC?

Laura Imrie suggested that she did not think it was the role of IPC guidance to look at ventilation, as no member of the group felt they were qualified to comment on ventilation, and this in itself we say is

quite remarkable.

A further key issue with the guidance is the way in which changes were and, conversely, were not made to it. There were many iterations of the IPC guidance, causing mass confusion, mistrust, and likely contributed to non-compliance by healthcare workers. Many of the changes were minor and likely of little consequence. But at the same time, changes which should have been made to reflect the evolving scientific knowledge surrounding aerosol and asymptomatic transmission were not made in a timely manner or at all.

Further, there was a lack of openness and honesty about the way in which the changes were communicated, particularly in relation to decisions to downgrade the requirement for healthcare workers treating Covid-19 patients, or suspected Covid-19 patients, to wear FFP3 masks to FRSMs.

Professor Gould stressed the importance of transparent communication in this regard and Dr Barry Jones added that the healthcare workers would have understood if those in charge had said, "Look, it's tough, there's a world shortage of PPE". Instead, there was a continued insistence by Dr Ritchie, including and up until she gave evidence to this Inquiry, that Covid-19 was predominantly spread by droplet and contact

transmission and that the guidance was fine.

As a consequence, there is evidence that healthcare workers didn't accept the guidance intellectually because it was intellectually dishonest as to how decisions had been arrived at. And this was made particularly stark in the evidence of Ms Nicholls, who said:

"... it felt like a big echo chamber and what our members were telling us in huge volume is that it didn't feel right on the ground ..."

On the issue of FFP3 masks, the Cymru group submits that the IPC cell became too tied in to the need for a high level of evidence to prove that FFP3 masks were more effective. What was needed was a common sense approach. When people's lives are at risk, it's better to be safe than sorry.

The extent to which the availability or otherwise of these masks was driving policy decisions remains a concern for the Cymru group.

I move on to concerns surrounding the implementation of the IPC guidance.

First, the Welsh Government had long been aware that the NHS estate in Wales was a real barrier in the implementation of effect of IPC measures more generally. Difficulties were brought into sharp focus at the outset

of the pandemic. But notwithstanding this, little was done by NHS Wales to mitigate the concerns relating to the NHS estate, and little was done by the Welsh Government to ensure national oversight on the issue. And this represented a missed opportunity.

Second, many of our members witnessed healthcare workers failing to adhere to IPC guidance, most notably filling to wear the correct PPE appropriately or at all. A concerning discrepancy has emerged, we say, between healthcare workers and operational leads as to the availability of PPE in the early stages of the pandemic. Policy and operational leads swearing blind that there were no supply issues on the one hand and the healthcare workers' lived experiences being ones whereby they felt unsafe in work due to non-availability of PPE.

Where PPE was available, what was being done to mitigate compliance and complacency fatigue? What was being done to ensure that staff wore PPE correctly, to combat, as Ms Marsh-Rees said, the chin wearers? Ultimately, non-compliance with guidance was not acceptable and placed vulnerable patients at avoidable risk and should have been prevented.

Third, the Cymru group is concerned by the lack of proper segregations of patients in Welsh hospitals. There was supposed to be a traffic light system in

place, but those we represent witnessed non-Covid patients being placed on Covid wards and Covid patients being placed on non-Covid wards, people being nursed in corridors, an inconsistent utilisation of the traffic light system.

Members intervened to asked for their loved ones not to be placed on a Covid ward, including one family member who was immunosuppressed. They were still placed on a Covid ward, where they contracted Covid and died.

Suspected Covid patients were also kept on wards until they tested positive. We say this was a total failure of common sense.

A Welsh Government report disclosed to the Inquiry acknowledged that nosocomial transmission was widespread in health boards, acknowledged that it was a major safety and quality concern for all NHS organisations, acknowledged that something needed to be done.

The report highlighted that in the week ending 14 February 2021 a Wales total of 211 hospital cases, definite or probable were reported, representing 8% of all confirmed Covid-19 cases and 53% of total Covid cases within Welsh hospitals.

What is particularly distressing for those we represent is that nosocomial transmission was worse in the second waves, despite there being a period in summer

of 2020 when lessons should and could have been learnt from the first wave.

Instead, no lessons were learnt. The rates of nosocomial transmission in hospitals increased, and more people died as a result.

The evidence, we say, betrayed a belief that nosocomial transmission was an inevitability, and underlined the concern of the Cymru group that the guide as was merely a sticking plaster covering a festering wound.

We have heard from many witnesses, including Dame Ruth May, that testing played a vital role in reducing nosocomial transmission. Despite this, Wales was later than England in introducing PCR testing of asymptomatic healthcare workers and were also later in introducing routine testing of all healthcare staff when lateral flow tests became available.

On the latter, it wasn't until December 2020 that the Welsh Government's policy requiring routine testing of all healthcare workers was announced. The evidence before this Inquiry is that Sir Frank Atherton knew about the importance of regular testing as early as 4 May 2020.

When asked about the government's delay in introducing testing, we have been given different

excuses. Sir Frank took little responsibility and blamed the UK Government, stating that policy leads at UK level didn't communicate rapidly with their counterparts in Wales. A different excuse was suggested by Andrew Goodall and Vaughan Gething grounded in the absence of LAMP technology in Wales, but this does not explain the delay in implementing regular testing with LFDs which were available to all four nations from the same date.

The reasons for the delay therefore remain unclear.

To compound the delays, despite the Welsh Government's announcement in December 2020, the rollout of routine testing of all healthcare workers in Wales did not, in fact, commence until January 2021, and was not implemented on the ground until as late as July 2021 in some cases.

Again, there has been no clear explanation for this delay either. Senior witnesses such as Vaughan Gething did not appear to be aware of the delay in rolling out routine testing until the commencement of this Inquiry and, most notably, the witness statement of Professor Kloer. And this begs the question as to why the Welsh Government wasn't taking a proactive view and proactive steps to monitor the rollout of the testing

programme and ensuring that Welsh Government policy was being implemented.

Wales was also later than the other UK nations in introducing regular testing for patients. It was only in January 2021 that the Welsh Government first recommended testing of all patients on admission, with further testing of asymptomatic inpatients at day 5, and it was only in March 2021 that the Welsh Government recommended a regime of re-testing of hospital patients at five-day intervals.

A further area of concern for the Cymru group relates to escalation of care. The powerful impact evidence of Paul Jones and the distress that he and his wife Karen suffered when their daughter Lauren was not escalated until her oxygen levels became dangerously low will no doubt still be with the Inquiry.

Key Welsh witnesses have been at pains to stress that critical care capacity was never breached in Wales and that decisions as to which patients should be prioritised for escalation were never required. However, it's unlikely that this is correct.

Andrew Goodall was questioned at length regarding the adequacy of Welsh data and, put bluntly, the data was completely deficient. The Inquiry heard important evidence from Professor Summers and Dr Suntharalingam

who opined that variations in decision-making and conscious or subconscious application of clinical thresholds are likely to have occurred and that ICU admission changed via local informal processes, meaning those who might ordinarily be admitted, were not.

Vaughan Gething accepted this in his evidence, that the Welsh Government's assurances regarding not reaching critical care capacity did not necessarily mean that all patients in Wales were escalated at the right time and received the treatment they needed.

Indeed, accounts given by the bereaved and those working on the front line in Wales point towards healthcare workers feeling pressured to make decisions about escalation and access to critical care, patients being turned away from critical care who would otherwise have been admitted, dilution of nursing ratios, and gatekeeping access to treatment.

This evidence plays on the minds of those I represent, many of whom had loved ones who died outside in intensive care units or respiratory wards. The torturous thought of what might have happened if only their loved one had been ventilated sooner, or at all, and the wondering of whether their loved ones would have been able to celebrate this Christmas with them if only they had had access to the care they would

otherwise have received in peacetime.

Rather than congratulate themselves for never breaching critical care capacity, the Cymru group asks the Welsh Government to look behind the data towards the material reality of what hospitals looked like for those patients who desperately needed care. The data does not tell the whole story, it does not show the conscious and subconscious decisions made by doctors, the diluted nursing ratios, whether there was sufficient capacity for ventilators, medication, equipment and consumables in the hospital where it was needed at the time it was needed.

In a similar vein, the Cymru group continues to hold concerns regarding inappropriate DNACPRs being placed on their loved ones without consultation of patients or family members. The evidence of Anna-Louise Marsh-Reese was particularly illuminating as she explained that on the one hand, her father's treatment escalation plan suggested that he was for CPR, whilst the DNACPR document itself suggested he was not.

A lack of digitisation of DNACPRs and treatment escalation plans in Wales renders wholescale audits virtually impossible and this, in itself, is unacceptable and should be rectified.

I close by drawing upon the words of Anna-Louise

Marsh-Reese who said in respect of the Cymru group:

"... most of our loved ones were older. They led very silent, quiet deaths ... it's almost death by indifference ... nobody communicated to them, nobody told them what was happening, they didn't have communication with their loved ones ... I really do think we need to ponder on ... that element of it. It's those quiet, silent deaths that are the real tragedy ..."

My Lady, the Cymru group is grateful to the Inquiry for supporting its ongoing participation in the Inquiry and looks forward to developing its position on the evidence and advancing constructive and measurable recommendations across the wide range of issues within its written closing.

Diolch, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Gowman, as persuasive as ever. Thank you.

I think now it's Ms Mitchell.

Closing statement on behalf of the Scottish Covid Bereaved by MS MITCHELL KC

MS MITCHELL: I appear as instructed by Aamer Anwar & Company on behalf of the Scottish Covid Bereaved. In Module 1 we heard about the lack of expertise about the oncoming pandemic. In Module 2 we heard the experts

struggle to be heard by the politicians. In Module 3 there was a critical failure by the IPC and ARHAI to properly listen to the experts, many of whom were on the front line dealing with Covid.

After a week of evidence in this hearing, infection experts were asked: if there was one thing that they could recommend to the Chair, what would it be? Their answer was one word: ventilation.

One of the Scottish Covid Bereaved members, Maggie Waterton, who gave evidence earlier this week, pointed out that in 1860, some 164 years ago, and long before discussions about the aerosols and droplets dominated the issue, a book was published which stated, at the outset of its introduction, "Ventilation". It continued:

"The ... first cannon of nursing, the first and the last thing upon which a nurse's attention must be fixed, the first essential to the patient, without which all the rest you can do for him is as nothing, with which I had almost said you may leave all the rest alone, is this: To keep the air he breathes as pure as the external air, without chilling him."

Yet why is this so little attended to? Even where it is thought of at all, the most extraordinary misconceptions reign about it.

This book, Notes on Nursing, was written by the woman that some of the emergency Covid words were named after, Florence Nightingale. It seems that failure to listen to the people on the front line is not a new phenomena.

These submissions will highlight the four important issues for the Scottish Covid Bereaved, although, of course, there are many more, and those will be addressed in written submissions too.

The first, hospital-acquired infection. Sadly, the Scottish Covid Bereaved were witnesses to the frontline failures which led to such significant hospital-acquired infection. The lack of adequate or sufficient PPE, the failure to control movement of patients around the hospital, the failure to control people outwith the hospital mingling and returning.

They attended hospitals in their own PPE. They saw PPE that was being used inappropriately by health workers, who had no option due to scarcity. They've come to learn through this module of the woeful failure of the IPC to act with speed when it was clear that aerosol was a significant method of transmission.

As already highlighted by my learned friend Ms Gowman this morning, the IPC seemingly did not consider ventilation a matter for them.

We have seen the failure of ARHAI to follow its own procedure to have a clear line of management or supervision. They have come to learn from the evidence of Laura Imrie, clinical lead of ARHAI and member of Covid-19 review group, that the two main considerations in not employing the precautionary principle were a lack of stock and insufficient fit testing.

Equally as extraordinary, we found that our politicians in Scotland, Jeane Freeman and Humza Yousaf, were unaware that advice on PPE was being tendered to them on this basis. Each would have wanted to know.

First Mr Hancock suggested that it was important that real-world solutions be found and, as such, the availability of stock was, of course, a factor to be taken into consideration. The charade of suggesting that the NHS as a whole never ran out of appropriate PPE must be measured by the circularity that the advice being tendered on what was appropriate was being influenced by the stock held.

For the sake of brevity here, the Scottish Covid Bereaved adopt the submissions of my learned friend Mr Stanton of the BMA in relation to IPC and the decisions taken on FFP3, and the observations of Mr Simblet KC for CATA in relation to his submissions on ARHAI. In summary, the bodies whose duty it was to

provide time-critical expert guidance to protect healthcare workers and society at large failed in that responsibility.

Two, DNACPR. It was and remains of enormous concern to the Scottish Covid Bereaved at the time that DNACPRs were most likely to be used that significant flaws in the use of those orders were exposed.

Despite best efforts of counsel to the Inquiry and also questions from the Chair, it is still not understood by the Scottish Covid Bereaved why, if it's a fundamental tenet of the DNACPR process that the informed views of the individuals or family are required before consent was granted, this was not happening.

Everyone who gave evidence confirmed the centrality of the individual, person-centred approach, and also seemed at a loss as to why this had gone wrong. Sadly, the Scottish Covid Bereaved have a number of examples of DNACPR notices being placed on record inappropriately or without the knowledge of families, whose concern now is that consent to such a course was never properly obtained. Many did not know of these notices until records were obtained after their loved one's death. Nothing heard in evidence has explained why these issues arose or comforted them that DNACPR orders were being properly considered and applied.

Three, visiting.

In relation to visiting and contact with loved ones, the Scottish Covid Bereaved felt the direct impact of the lack of proper rules and guidance to provide a proper system of visiting and communication with loved ones who died from Covid. There seemed no system or procedures to be relied on and the ad hoc nature of the decision-making on who could have contact with their loved ones, in what way, and for how long, seemed entirely arbitrary.

As highlighted in evidence, this has left enduring trauma with those who lost loved ones who were not able to see with them or be with them in their final hours.

Those who were able to see their loved once were sometimes confronted with a choice between attending at the side of their loved ones in their last moments or attending their funeral, choices which no one should have to make.

A running theme in respect of visiting was that of consistency, and it's important to the Scottish Covid Bereaved to know that they were being treated or should be being treated equally. One of the most difficult things for those who lost loved ones was to find the different levels of care and consideration that were given to people. This has been no more painful than

some finding out that whilst they were not allowed to see loved ones at the last moments, others were. Some were allowed to visit, others were not. A consistent and compassionate policy is required for all. A pandemic must not be allowed to remove our humanity.

Four, the failure of rights-based approach.

The Equality Act provides public sector equality duty on the Scottish Government to assess the impact of applying proposed new or revised policies. And of course the purpose of that is to seek to eliminate discrimination, harassment or victimisation, to advance equality of opportunity for those who share relevant characteristics with people who do not share it. Especially pertinent for a pandemic are the protected characteristics of age, disability, pregnancy, maternity and race.

The fact is that when it was most crucially important to have these matters highlighted in the decision-making process about healthcare decisions in a pandemic, we were told that there was simply not enough time to carry out that assessment.

The Scottish Covid Bereaved did not need to be reminded that these decisions were being carried out in a pandemic. As we saw with the UK Government in Module 2, in times of crisis those most in need, those

most vulnerable, were not given the proper place when decisions were being taken. The Scottish Covid Bereaved do not accept that when decisions are being taken no equality impact assessments could have been carried out. Even where time sensitive matters arose, decisions simply ought not been taken without reflection and some form of assessment as to how this would affect, for example, older and disabled people, the most vulnerable in society and certainly the most vulnerable to this pandemic.

If the cumbersome method of equality impact assessment did not work, an alternative method ought to have been implemented. A failure to ensure the impact of any policy or procedure before implementation which might affect the vulnerable was therefore not properly considered.

Decision-making without reference to this is unacceptable and responsibility to flag up problems after the fact is not the responsibility of those advocating on behalf of the vulnerable, as might have been suggested.

Moving to recommendations. The Scottish Covid Bereaved wish to thank the careful consideration which has been given to recommendations by all the core participants and we will consider these when it comes to

proposing recommendations for the chair.

Amongst propositions which we will seek to provide to the chair in much greater detail, relate to the following few examples.

One, it must be known by every politician that the UK -- in the UK that staff and infrastructure in the NHS needs investment. How, practically, recommendations can be made to improve this will be difficult but it shouldn't stop us trying. The Scottish Covid Bereaved consider that despite what politicians said, the NHS was overwhelmed. The counting of beds is not a useful metric. The fact is that the most important resource, those who work for the NHS, were overwhelmed, and those that remained are still suffering the psychological consequences. Beds are useless if you don't have staff to care for the people in them.

The Scottish Covid Bereaved are far from convinced that had the Louisa Jordan been required, too, there would have been staff to use them.

We seek to make recommendations in relation to practical steps, such as suggested, to create greater flexibility in the workforce, including training in ICU, so that people were not learning this task on-the-go.

Visiting wards. Having family liaison officers on ICU to reduce the moral injury to those who are dying

and to those who are losing loved ones.

Two. The institution of a citizens assembly, or other formal government structure, to develop moral and ethical principles for a just and fair allocation process for healthcare where demand exceeds supply; to advise on visiting plans to allow a consistent and fair approach; to bridge the gap of the training of staff to provide flexibility, so that people, once again, are not learning on the job.

Three. DNACPR. Recommendations will be made to address the role of what was described as aggressive healthcare towards the end of life, to facilitate and promote discussions with people and their loved ones about planning for the end of life and what they want.

This chimes with the recommendation proposed by Professor Wyllie that communications about end of life should be normalised between patients, clinicians and their families, to consider that this is a vital part of care; the use of ReSPECT forms, as advocated for by Dr Suntharalingam as standardised across the nations. Again, the issue of consistency. So that, as described by Maggie Waterton on behalf of the Scottish Covid Bereaved, people can be treated with care, compassion and the centre-based approach.

Four, data. A recurrent theme in this Inquiry,

data needs to be gathered intelligently with reference to all relevant markers, centrally collated and transmitted across the four nations; a health data officer for each of the four nations, mirroring the role of the CMO.

In relation to hospital-acquired infection, a full review of the IPC in ARHAI guidance and, importantly, understanding the basis on which this is made, making these bodies transparent and accountable through processes and procedures, easy to understand.

Six. Paramedics and ambulance staff. The submissions just made by my learned friend Mr Jory KC, which we have just heard, will be considered with care. Amongst our number was a paramedic who lost his life returning after retirement.

Seven. Recommendations to significantly reform the HSE. HSE guidance showed that as a public body it is not fit for purpose. The inexplicable decision to set a threshold for reporting that was more difficult to meet than would have been in non-pandemic times meant that a proper understanding of problems arising and accountability for that has been lost.

Eight. Recommendations in support of addressing issues of racism and misogyny in the NHS, the fitting of masks being a prime example in the respect of healthcare

workers. Of course, my Lady cannot simply reform society by recommendations, but it's not, of course, a reason to bring forward recommendations to try and address these in a practical way.

Now turning to thanks, my Lady.

The healthcare system, as I've already stated, isn't beds, it's people. We acknowledge and endorse the submissions made by my learned friend Mr Jacobs on behalf of the Trades Union Congress, and the submissions made by Ms Sen Gupta KC on behalf of the Frontline Migrant Health Workers and witness W1. We thank all the people, brave in the face of this pandemic, who worked in hospitals trying to keep our people safe at great personal risk and sacrifice. No one should have been called upon to work in the conditions to which they were subject.

It's important that we understand what happened, that we consider how to do things better. History is littered with examples of societies that do not learn from their mistakes. Let this Inquiry not falter at ill-informed and superficial criticism of its important work. Everyone who contributes to ensuring this Inquiry from the chair, Counsel to the Inquiry, and the legal and admin teams, to those whose work is keeping the smooth running of the witnesses in attending and the

safety and security of this building, everyone plays a vital part in ensuring we are better prepared for Disease X. We thank you all for your commitment and dedication to this process.

Finally, the worth of the work that is being done will be measured by the recommendations made if, and only if, those who are tasked to protect society listen and implement those recommendations, as my Lady reflected on yesterday. The Scottish Covid Bereaved wish to make it clear, therefore, to politicians that they have heard enough of condolences. The legacy of those in this group who lost loved ones is to ensure that changes take place so that families in the future, our families, do not lose loved ones or suffer the additional burdens that losing loved ones in the pandemic brought for them.

To that end, we want the UK and Scottish Government and public bodies to state and restate at every opportunity their firm assurance to implement crucial recommendations my Lady is to make that are required to keep us safe come the next pandemic. Our lives and those of our loved ones depend on it.

These are the submissions on behalf of the Scottish Covid Bereaved.

LADY HALLETT: Thank you very much indeed, Ms Mitchell, and

thank you, your submissions were as focused and as constructive as ever, and I know that the whole Inquiry team are very grateful for the support that those you represent have provided, so thank you very much indeed.

Ms Munroe, I gather you've been in an accident, you poor thing. Don't stand, please.

Closing statement on behalf of Covid-19 Bereaved Families for Justice by MS MUNROE KC

MS MUNROE: My Lady, thank you.

I make these closing submissions on behalf of Covid-19 Bereaved Families for Justice UK.

If I may start by a few quotes:

"We couldn't understand why the government basically didn't appear to be doing anything."

John Sullivan, Day 2.

This week from Dr Saleyha Ahsan: there was a disconnect between the politicians and decision-makers and the patients and doctors. She was a woman who wore her numerous hats with such grace, a doctor, a film maker, an activist, a bereaved daughter.

"... we couldn't get appropriate equipment, appropriate aprons, so we seriously considered using bin bags and literally cutting a hole in them ..."

Mark Tilley, Day 14, paramedic.

"I borrowed some scrubs from the neighbouring trust, an acute trust. We bought visors and goggles off the internet. That was something that we asked for. That wasn't included in the original PPE that we had, but we needed that specifically for our cohort of patients ..."

Dr Tilakkumar a junior doctor redeployed to ICU.

"I feared losing my job. Everything was closing down at the time. I suffer a great impact from all this situation. This fear of becoming ill, I had an obligation towards my family, the whole thing caused a lot of stress. Eventually I lost a lot of weight due to the stress."

An IWGB cleaner on Day 19.

Those I just quoted were part of a cohort of witnesses that were described in this module as "impact witnesses".

The word impact means "a marked effect or influence or, when used as a verb, to have a strong effect on someone or something."

To those I've just described as the impact witnesses, I would add the likes of: Professor Fong; Professor Summers; Barry Jones; Julia Jones, who highlighted the need to prioritise people over institutions and consider individual needs over

wholesale edicts; Tracy Nicholls, the chief exec of the College of Paramedics; Tamsin Mullen.

What all these witnesses, including those from all the families from the devolved nations have in common was that they spoke truth to power. That's an interesting phrase, "truth to power". In classical Greek, truth to power was known as "parrhesia", literally meaning to speak everything, to speak freely, to speak boldly. The concept was popularised in the 1960s by black civil rights activists such as Bayard Rustin, whilst philosopher Michel Foucault once noted that:

"Speaking truth to power often requires those who pursue it to confront personal and social risks. It requires courage."

The evidence from the impact witnesses and witnesses such as Professor Fong, and those that I've mentioned, all showed huge amounts of courage, and we say they should be afforded the greatest of relevance and prominence by this Inquiry. What they had to say was visceral, it was powerful, it was real.

Now, whilst it is good that these witnesses made an impact in this room, because I'm sure they did, for their suffering, their trauma, their insight, their lived experiences to truly be valued, to be a marked

influence or to have a strong effect on someone or something, their words must have an impact on this Inquiry's findings, its recommendations, and resonate beyond these four walls.

My Lady, we say that the evidence that this module has heard has fortified our opening oral and written submissions. The resilience, preparedness and capacity of our public health and social care and civil contingency infrastructure was fatally undermined by underfunding. Without proper funding of this infrastructure and resources, change is impossible.

Our families reiterate our call to the Inquiry to reflect this fundamental truth in its findings and recommendations. We propose to consider five points in these submissions. There are, of course, other vitally important topics such as airborne transmission and nosocomial infection that we won't be mentioning in this submission, not because we say it's not important, they will be in detail in our written submissions. And we know that you have been addressed at length and in detail by other CPs on those topics.

Finally, my Lady I will turn to some recommendations.

So, first, preparedness and resources. The NHS was not in good health. It was malnourished, starved of

proper resources. It was not in its first bloom of youth and feeling its age. The infrastructure creaked and groaned under years of underfunding. The NHS was not prepared and one cannot divorce to that from the socioeconomic reality and context of years of lack of investment and the consequential lack of resources.

The UK was at the bottom of the international league table of comparable countries for just about all resourcing metrics.

Emergency planning cannot either take place or cannot be implemented if resources are stretched even in normal periods. Where one has a health system which is overstretched to breaking point and a dearth of preparedness, the inevitable will happen. That system will not be able to adapt to emergency situations.

My Lady, we are grateful to this Inquiry for the instruction of a wealth of excellent experts. We've all benefited greatly from their evidence. Many of them have highlighted the very issues of most concern to the families we represent, and the under-resourcing of the NHS has become a recurring theme throughout this module, a theme that simply cannot be ignored.

Just four examples:

Ruth May, on Day 6 spoke of there being nearly 40,000 vacancies nursing and midwifery.

Professor Adrian Edwards on Day 9 spoke about the situation in relation to GPs.

Kevin Rowan, on Day 16, in relation to health and safety.

And, as ever, Professor Fong's words were particularly trenchant. He said on Day 12, in relation to one of his visits:

"We went to another unit where things got so bad they were so short of resources, they ran out of body bags and they were instead issued with 9-foot clear plastic sacks and cable ties, and those nurses talk about being really traumatised by that because they had recurring nightmares about feeling like they were just throwing bodies away."

The figures from the Intensive Care Society indicate that the UK went into the pandemic with just 7.3 critical care beds per 100,000. Germany had 28 per 100,000. The Czech Republic, 43.2.

Now, my Lady, we all know that public inquires are hugely expensive, a point often cited by detractors to say why they shouldn't be held. And it could be said, perhaps with some justification, that in the public consciousness the names of those judges presiding over inquiries in the past, Saville, Scarman, Macpherson, Chilcot, Leveson, et cetera, are better remembered than

the details and the recommendations of the actual inquiries themselves. But any public inquiry mustn't be fearful in looking for the truth and making findings of facts and recommendations.

And an inquiry can, we say, offer a number of significant, important and healing factors. It can be cathartic, it can restore public confidence, and of course a phrase that we've heard many, many times thus far and I'm sure we'll hear in future modules, learning lessons.

A public inquiry can also illuminate and shine a light on facts and opinions that are frequently hidden from public view.

Now, my Lady, we understand that this Inquiry cannot dictate government fiscal policy. There may be some in society at the moment who think they can, but we are not expecting or asking you to dictate to the Chancellor how she allocates scarce resources. However, we do say that it is proper and indeed imperative that the recommendations that this Inquiry makes are informed by all the evidence.

We say it is both permissible and part of the investigative function of the Inquiry to identify the problem under scrutiny in this instant: chronic and acute underfunding of the NHS comparable to other

countries.

Engineering adequate resourcing going forward of course is not for the Inquiry. That must be addressed by the government in legislature. We have a new Labour government who were not in power during the pandemic. Clear unambiguous findings and recommendations from this Inquiry may, one hopes, find a more receptive political ear.

Secondly, capacity and overwhelm.

Our families say, my Lady, that a false narrative was cynically developed by decision-makers because there were, clearly, periods within the NHS was overwhelmed.

The NHS lacked the capacity to expand and withstand a surge in demand. The UK's overall response to Covid-19 is a story of failure. The UK, one of the wealthiest countries in the world, said to be having a world-leading health system, also ranks in the top 20 of countries in the world in terms of death from Covid-19 per 100,000 people.

As Saleyha Ahsan said this week, there was a disconnect between what decision-makers were saying, management and politicians, and what doctors and patients were experiencing. Whilst society clapped our hands and banged our pots for healthcare workers every Thursday, at the same time, in hospitals across the

country, staff and patients were facing trauma in every sense of the word.

The evidence in this module has established that many parts of the healthcare system were overwhelmed at multiple points, yet there is still the false narrative perpetuated from the very top of the government down through decision-makers, and we urge the Inquiry to call this out. The so-called "success" that Mr Hancock and Mr Johnson talk of is disingenuous and an insult to the staff and patients.

Talking of Mr Hancock, there was, of course, an understandable spike in attention amongst those who attended the Inquiry but the wider watching public when he came to give his evidence. My Lady, I of course make these submissions on behalf of the families I represent. I'm their legal conduit through which they wish to make their feelings known and I hope I do so in a temperate manner. However, the Inquiry should be in no doubt as to the depth of feeling from the families about Mr Hancock and his evidence. To put it mildly, feelings run extremely highly.

Ms Carey King's Counsel played part of Professor Fong's evidence to the former health secretary and he was lost for words. Indeed, Mr Hancock and Professor Fong make for an interesting comparison.

Firstly, both visited hospitals. Professor Fong described his visit as peer support visits, offered to hospitals and ICUs across England. His evidence, we say, was an emotional knock-out punch in terms of its content and delivery. Not just for those of us in the room, but the thousands who watched and the millions -- and it really is millions -- who have rewatched and shared his evidence online. We were all left reeling from it.

Mr Hancock, in contrast, described his visit to the hospital as him doing "a night shift". With the greatest of respect, he did not.

Our families say putting himself in the same sentence as a healthcare worker in ICU was breathtakingly arrogant. Mr Hancock and the ICU staff he encountered were not on the same page, not in the same chapter, not in the same book.

Those healthcare workers were experiencing the horrors Professor Fong so vividly described. That Mr Hancock would centre himself as doing a night shift when in fact he was cosplaying, perhaps for PR purposes, was unedifying.

Both Mr Hancock and Professor Fong spoke about the conditions in the hospitals. Professor Fong spoke of units stretched to breaking point, nurses crying in

their cars before going on shifts, describing the scenes in ICU like a terrorist attack and saying that that was not a hyperbolic sentence.

Mr Hancock brazenly maintained that the NHS coped.

My Lady, I said our families had very strong views about Mr Hancock and his evidence. They do. They are angry, they are frustrated, they are astounded, they are tired. Tired of ministers and decision-makers who will not take responsibility. Tired of the false narrative. Tired of the disingenuous portrayal of how we as a country, and specifically the NHS, fared during the Covid-19 pandemic. And they ask simply: how could you, Mr Hancock, come to this Inquiry and still peddle that false narrative? How could you and your government allow healthcare workers and patients to be in those awful conditions as a direct result of the abject failure to properly and adequately plan and prepare? How could you allow so many people to endure those conditions in hospital and have no dignity, even in death?

And then there was Sir Christopher Wormald. To be succinct, my Lady, those who listened to his evidence, and certainly our families, found it to be an object lesson in obfuscation, a word salad, so many, many words, so very little substance.

What we saw in both Mr Hancock and Sir Christopher was institutional defensiveness at its highest form. Although sympathy was tendered on behalf of the bereaved by politicians with expressions of sorrow, humbly offered in hushed tones, that fell flat for our families listening and watching.

Discrimination. My Lady, it is vital that one does not group all discrimination into one amorphous mass. Different types of discrimination impact upon different groups within the population in very different ways.

It is important that the Inquiry does not use such catchall phrases as "vulnerable" and "vulnerability" to describe discrimination. These are very different entities.

When the Inquiry comes to make its recommendations in relation to discrimination, it is vital that clear demarcations are made. Each group needs to be considered separately, and for each group there needs to be an identification of the distinct structural, institutional and socioeconomic issues which underlie how the discrimination and unequal outcomes impacts upon that group.

Turning then first to the issue of race.

My Lady, we adopt and endorse the submissions from

FEMHO eloquently and powerfully made by Professor Thomas KC and the definitions of structural and institutional racism he explained.

We further say this in relation to this topic. Although its arrival coincided with the birth of the NHS, not all BAME healthcare workers came to the UK on board HMS Windrush in 1948. No, black and brown people from the Caribbean, the African continent, the Indian sub-continent, have left an indelible mark on this country going back hundreds of years.

Ask any Caribbean or Asian person if they have a nurse or doctor in their family and many will point you to an old black and white photograph of a grandmother or grandfather or mother and father proudly posing in a crisp white doctor's coat or in a starched nurse's uniform, with a neat white bonnet atop a perfectly coiffed 60s hairdo. I know I can point to such a photograph.

Black, Asian and minority presence in the NHS is perhaps unique in this country in relation to any other profession. The NHS recruited doctors and nurses from all BME backgrounds almost from its inception in 1948. They were needed to staff the wards, the surgeries, the clinics of the fledgling NHS. The call was put out and as usual it was answered. They came in their thousands.

In no small measure the NHS was built upon and continues to be sustained by immigrants.

There have been successive waves since the 1960s, nurses and doctors from east, west and southern Africa, from Asia, nurses from the Philippines. Black and minority ethnic staff make up almost a quarter of the workforce of the NHS, yet they were substantially over-represented amongst those who succumbed to Covid and died. It begs the question, why? Why was such a huge and vital part of the NHS workforce so badly let down? How, they ask quite rightly, were we forgotten and neglected?

Professor Thomas offered some answers and we endorse those: the hostile environment which meant that BME workers did not feel empowered to challenge things such as lack of PPE; and whilst Scotland and Wales and Northern Ireland all presented slightly different problems, discrimination and particularly institutional and structural racism were the same consistent features across the whole of the United Kingdom.

We also endorse the submissions made on behalf of the frontline migrant workers by Ms Sen Gupta KC. We remind the Inquiry of the written evidence of the members of the Filipino consortium. One Filipino nurse remarked:

"We were chosen to be exposed."

Age discrimination. Ageism means stereotyping or prejudice or discrimination or discriminatory actions or practices against older people that are based on their chronological age. Despite the fact that the vast majority of older adults are not physically, cognitively or mentally impaired, age-related stereotypes persist.

The pandemic starkly revealed widespread ageism and age discrimination against older persons, a glaring example being in relation to DNACPRs, to which I will return.

Disability. My Lady, we endorse the submissions of Mr Burton yesterday -- Mr Burton KC yesterday in relation to disability. And we would like at this point to tell the Inquiry about another one of our families that you've not heard of hitherto.

Jane Roche lost her sister Jocelyn Pettitt to Covid-19 on April 2020. Jocelyn was 54 years old and had underlying health conditions. She suffered from anxiety and was deaf, with a cochlear implant. On 1 April 2020, Jocelyn began coughing uncontrollably and her partner rang 111, who advised, "Well, she's got a loose cough, stay at home, not to worry". Jocelyn continued to feel unwell, and on the morning of 4 April her partner fond her unresponsive and she was

subsequently admitted to Good Hope Hospital in Sutton Coldfield with aspiration pneumonia. Jane visited Jocelyn that day and noticed that she was dipping in and out of consciousness. Eventually Jocelyn's partner was allowed to visit her for an hour each day to help advocate on her behalf but Jocelyn was never conscious for those visits. Her cochlear implant was not in her ear. The family had no idea why that had been taken out.

Jocelyn tested positive for Covid on 6 April 2020, and was put on end-of-life care without her family being involved. On the 9 April she died.

Five days previously, Jane's father had died from Covid.

Subsequently, Jane saw her sister's medical records and saw that a DNACPR decision had been made about Jocelyn 45 minutes after she had been admitted to A&E. The family had not been consulted. Jane believes that the medical records portrayed her sister Jocelyn as being far more frail than she actually was.

Mental health. My Lady, we endorse the submissions of Mr Pezzani. Mental health provisions have often been seen as a poor relation of the NHS. And that is saying something. So one can imagine the parlous state those services were in coming into the

pandemic. CAHMS, in particular, and mental health provisions for young people were not fit for purpose. Mental health services were simply not considered in any detail or at all. And then when it hit home, such as the impacts on the mental health of healthcare workers, there simply were not the systems, the resources, the professionals in place to deal with it.

Four, primary care. Primary care was forgotten in the planning and consequently failed many who tried to access it during the pandemic. In our opening we took you on a journey, the patient's journey during the pandemic. The evidence we have heard in this module confirms our worse fears. That journey for many was a particularly arduous, often fruitless and ultimately painful one.

We've heard that the pharmacists were completely forgotten. There was a funding crisis, staffing problems in terms of actual numbers, retention, burnout. GP services were underfunded. The Inquiry's own experts have attested to this.

A lack of data and monitoring of primary care, NHS 111 and 999 services makes assessment of the extent of this difficulty hard but it is clear that many people did not reach the services that they needed. Those that did, often encountered insufficient IPC measures and the

effects of shortages of PPE and medical equipment and access to ICU.

The HSIB found that in March 2020 only 50% of 111 calls were answered at all and there is evidence for further problems in forwarding calls to more expert clinical advisers.

Contrary to the views of Sir Christopher Wormald, 111 did fail the public, not because of the hard-pressed staff but because of the failure of the system. This was a service where demand outstripped supply. That by definition is overwhelmed. The Inquiry's own expert, Professor Snooks, also concluded that both 111 and 999 services were at times overwhelmed.

Finally, DNACPR. This is an issue that is very close to the heart of many of our families with over 400 having their own stories, such as Jane's, and their experiences of DNACPR notices involving their loved ones in hospitals where they were not consulted. It is an issue which has grown and developed its own momentum during the course of Module 3 and, as the evidence has emerged and been explored, it has become patently apparent that the 400 accounts that we have are not alone. We say this is another instance of system failure.

In our opening, we asked the Inquiry to address

a number of questions in relation to DNACPR. Many of those questions have been answered. There was a lack of clarity and consistency with guidance, training, messaging, its implementation and interpretation across the country. There was a rise in DNACPRs during the pandemic and inappropriate use, particularly for groups such as the elderly, learning and physically disabled. Doctors working in extremis, their own mental health being shot to pieces, were placed in invidious situations with limited training and often no oversight.

The experiences of DNACPR during the pandemic have had a lasting impact upon trust between clinicians, patients and their loved ones.

Recommendations. My Lady we propose to set out our full recommendations in our written document but, for now, simply highlight four points.

One. Staff welfare and safeguarding measures including risk assessment, psychological and financial support measures.

Two. Patient and family welfare and safeguarding measures to maximise partnership and to promote support through responsible visiting and contact policies and individual critical care planning.

Establishing a fully functioning whole system healthcare IT infrastructure with parallel data

collection analysis and dissemination systems.

Establishing a comprehensive and dynamic healthcare system, pandemic plan, integrated into the wider governmental public health and social care planning.

My Lady, before I end, I should also say that on behalf of the families that I represent, we also adopt and endorse much of the submissions made on behalf of the TUC by Mr Jacobs, the BMA, from Mr Stanton, and CATA, from Mr Simblet King's Counsel.

We also support CVF's recommendation of a full review of all DNACPRs put in place from the start of the pandemic to date and a review of the notes of all formally shielded people from early 2020 to date.

And we also endorse John Campaign's recommendations for a new legislative right to a care supporter, such as a relative or friend, for all patients who would like this across all healthcare settings.

Thus, in conclusion, my Lady, our families continue to be committed to this Inquiry. Some attend each day and they sit behind me. Others are regulars. They do so with quiet dignity and courtesy and respect to the process. Many others watch online, they catch up when they can after work, they follow podcasts and

webinars. We as their lawyers are so fortunate to have such a diverse and informed group. Parents, children, doctors, nurses, social workers, a full gamut of healthcare workers. We also have managers from trusts, managers from local authorities, and care homes, academics, students, creatives from the arts and the media, people who have retired.

They are all united, initially in their grief, and they support each other, they remain engaged, invested, and hopeful that this Inquiry will be an important stepping stone on their journey for truth, justice and accountability. I'm sure that is the same for the families of Northern Ireland, Cymru, and Scottish groups as well.

My Lady, I share the thanks expressed by others to all involved in the running of the Inquiry, and to Ms Carey and her counsel team and the solicitor team for their collaborative approach in this module which has been particularly welcomed and helpful.

My Lady, finally, I'm not going to ask you to be bold or brave, because as a High Court Judge you had presided over some of the most high-profile and difficult cases across different jurisdictions. Boldness and bravery came with the territory.

My Lady, I know you've listened and you've heard

the words of the impact witnesses, witnesses like Professor Fong, Professor Summers, and the other experts. There is a great power in anecdotal evidence and lived experience. Their courageous words, speaking truth to power, once heard cannot but resonate and reverberate and draw you inexorably to make the findings and recommendations our families urge upon you.

Then, my Lady, right will be done. Thank you.

LADY HALLETT: Thank you very much indeed, Ms Munroe. Your accident obviously has in no way undermined your eloquence -- extremely powerful submissions, thank you.

Can I endorse what you said about Professor Fong. I probably shouldn't say this, but I'm going to do it anyway. I've been over 50 years in the justice system and heard a lot of witnesses, but I've rarely heard a witness as compelling as Professor Fong was. So thank you very much for indeed for your help, Ms Munroe.

Ms Carey, I think that completes the submissions, does it not?

Closing remarks by LEAD COUNSEL TO THE INQUIRY for MODULE 3

MS CAREY: It does. May I just add a few closing remarks.

In opening, in September, I referred to the volume of evidence obtained by Module 3 and it now stands at just shy of 17,000 documents, amounting to over 231,000 pages. Over the last 41 days of hearings, you

have heard from 96 witnesses and so there is clearly much oral and written evidence to consider and review and we are very grateful to the helpful closing submissions of all the core participants over the last few days, and we look forward to receiving their written closings in due course.

Finally, may I say this. On behalf of the Inquiry legal team, may I echo and add to the thanks that has already been given to all here at the hearing centre, who have helped make the hearings run smoothly. And can I thank all other Inquiry staff behind the scenes who have helped with the publication of Every Story Matters record, obtaining the expert reports, redacting and reviewing the huge volumes of disclosure that has needed to be made, each and all of them have provided us with significant assistance and support to this module and I really am very grateful.

Thank you, my Lady.

Closing remarks by THE CHAIR

LADY HALLETT: Thank you very much, Ms Carey.

As you say, thank-yous go out to such a long list of people and I'm not sure my voice would survive my saying the long list, so I'll suffice to say thank you to everyone who has participated in the Module 3 hearings in whatever capacity over the last 10 weeks,

obviously, but before in preparation. And thank you, too, to those who followed our proceedings in Dorland House and I know that some of them are very regular attenders, and to those who followed online.

As a result of the hard work and dedication of the core participants and the Inquiry team, of the material providers, an awful lot of people, I've heard important evidence about the devastating impact of the pandemic on those needing and those providing healthcare services across the UK.

Of course I've also heard, as well, from those who lost loved ones in tragic circumstances, and I'm particularly grateful to all of those witnesses who gave evidence of the impact upon them and, of course, to the core participants for their submissions, for their questions and their valuable input into the work of this module.

The Inquiry will now begin the task of reviewing all the evidence received in the module, both oral and written, I repeat and emphasise both oral and written, and we will prepare a report setting out my findings, conclusions and recommendations.

As many of the core participants present there this morning know, it's my firm intention to conduct as many public hearings as possible in 2025, and to

conclude those hearings early in 2026. So next year I shall hear evidence on vaccines, and therapeutics, procurement, Test and Trace, the care sector, children and young people, business and the economy.

Given this very busy but I believe essential schedule of hearings, there must be an impact on the time I will have available and my ability to dedicate it to the M3 report. But I will do my very best to get the report drafted, with the assistance of you, Ms Carey, and the Inquiry team, and I very much hope that we should be able to publish the M3 report in the spring of 2026. If I can publish the report sooner, then of course I will do so.

So again, many thanks to everybody for concluding the longest module in this Inquiry so effectively on the day and to the time predicted.

Thank you, all. I conclude this set of hearings.

MS CAREY: Thank you very much, my Lady.

(11.41 am)

(The Module 3 public hearings concluded)

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