Wednesday, 5 February 2025

(10.29 am)

MS CAREY: My Lady, good morning. I hope you can see and hear me all right.

Opening Introductory remarks by THE CHAIR

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

Good morning, everyone, this is the second preliminary hearing for Module 6, the impact of the Covid-19 pandemic on the adult social care sector. In a moment, Ms Carey King's Counsel, Counsel to the Inquiry, will outline the submissions and the issues that I have to hear today.

I shall then hear submissions from eight Core Participants. I am conducting the hearing remotely. One of the Core Participant's advocates, Mr Pete Weatherby King's Counsel will also be attending remotely but all other participants and the Inquiry team are all present at the hearing centre at Dorland House.

Ms Carey.

Statement by LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

MS CAREY: Thank you, my Lady. May I welcome all Core Participants who are present today, whether online or in person. I know many of them are known to you from your work in other modules, so forgive me for not introducing each one of them individually. Can I start, though,

with a thank you to all Core Participants who provided written submissions in advance of today's hearing. And with your permission, my Lady, can we publish those after the hearing today. It may be that I address some of the matters raised in those submissions as we go through today's agenda.

So, turning to the agenda, the first item is Rule 9 requests and an update. Since the last preliminary hearing, which was in fact back in March of last year, Module 6 has, in my submission, made good progress in preparing for the public hearing this summer, not least in obtaining evidence pursuant to Rule 9.

As at today's date, Module 6 has issued 104 Rule 9 requests, from the relevant organisations and individuals, and that includes the major government departments and ministers, local government organisations, the regulators, the public health agencies, trade unions, and a wide range of interest groups, organisations and charities, representing those who both provide and, indeed, receive adult social care.

To date, 26 statements and one questionnaire response have already been disclosed, and there are a further 50 statements that have been received in draft and are in the process of being finalised and progressed for disclosure.

But, my Lady, there is no room for complacency, in my submission, and there remain a small number of recipients of Rule 9 requests where the Inquiry is becoming concerned at the slow progress of draft statements and, in particular, late requests for extensions to deadlines, especially where the deadline has already been extended.

The Inquiry appreciates that across all its modules the Inquiry has made a number of requests of the main government departments and certain key individuals. Given the centrality of some departments and ministers in the pandemic, that was perhaps inevitable, and the Inquiry understand that work needs to be prioritised and the modules that come before Module 6 will inevitably come first.

However, we cannot and do not ignore the importance of this evidence to this module, and the Inquiry has been working hard with the relevant legal teams to devise a workable and realistic plan for production of the statements and any accompanying documents.

So may I, through you, my Lady, at this stage, urge all material providers to redouble their efforts, whether that be providing draft or indeed final statements, to ensure that disclosure is made in good time.

I know that one of the Core Participants this morning asked you to impose a deadline by which the bulk of disclosure is made, but given the ongoing progress, and the fact that there is much hard work ongoing across this module and other modules, we would ask that you do not make such an order.

Indeed, if it assists those listening this morning, there are a number of draft and final statements that are due to be received by the end of February. And that includes from the Public Health Agency in Northern Ireland, DHSC, the Ministry of Housing, Communities and Local Government, and statements from the LGA and COSLA in Scotland.

And I know that the Inquiry legal team will of course be prioritising those for review so that disclosure is made as promptly as possible, and we thank all the material providers in advance for meeting those deadlines.

Given the number of Rule 9 requests already made, the Inquiry legal team considers that the majority of Rule 9 requests have now been sent. A number of Core Participants today have made helpful suggestions: in excess of 35 individuals or organisations have been suggested to whom Module 6 might send a Rule 9.

Some of the proposed recipients are, in fact,

already preparing statements for the Inquiry, for example we understand that the Chief Social Worker in Northern Ireland is preparing the statement on behalf of the Department of Health in Northern Ireland. There has been a request that Jonathan Marron and Michelle Dyson provide statements on behalf of DHSC, and in fact they are already providing the draft statements. And there is one particular request that we -- Rule 9, the Health and Safety Executive, and indeed that Rule 9 has in fact now been drafted.

The additional requests are under active consideration, but it is likely that if further Rule 9s are to be sent, the number will be significantly fewer than 35.

May I give just one example: the Inquiry is asked to send Rule 9 requests to the relevant ombudsman in each country. In our submission, examining complaints of the ombudsman and/or how those complaints were handled is not a matter that is within the scope of Module 6. It runs the risk, in our submission, that individual cases and complaints may become the focus of any evidence that is provided, which would be contrary to the Inquiry's terms of reference, which expressly state that individual cases will not be considered in detail.

Further, in our submission, the concerns about the

adult social care sector's response are already apparent in the evidence that has been disclosed to date, such that it is in fact not necessary to send Rule 9 requests to the ombudsman.

Can I turn to a discrete work stream and the approach that Module 6 is taking to gathering evidence from individual care and nursing homes.

By way of background to date, the Inquiry legal team has sent a number of Rule 9 requests to organisations that run or represent residential care and nursing homes, but, in addition, the Inquiry wishes to gather evidence from individuals who managed the care homes during the pandemic. And in order to do so, the Inquiry intents to issue a small number of Rule 9 requests, numbering no more than approximately 22 in total, to a selection of care homes from across the UK.

Now, my Lady, may I make it clear, this evidence is not intended to be representative of the issues faced by each and every care home, nor could it be. Nor is it a comparative exercise, and I must stress that. The sheer number of care homes across the UK and the breadth of care provided means that, in seeking to draw comparisons, it would be an impossible, if not a futile, task, and I should make it clear that the aim of this exercise is not to either praise or criticise any

individual care home, but it's designed to obtain evidence from those on the ground, from which any common issues or themes might emerge.

The care homes have been selected by the Inquiry legal team and include care homes of varying sizes, who provide a range of services, which are located in a mixture of urban and rural settings, some which are state run, others run by the private sector. And they cover areas of the UK where there was both high and, indeed, low prevalence of Covid-19. In our submission, approaching this exercise in this way will provide you with a broad range of evidence from the care homes themselves and the impact of the pandemic on them.

Item 2 on the agenda deals with disclosure to Core Participants, and forgive me if this sounds like a shopping list of what we have done, or not yet done, but, to date, Module 6 has made eight tranches of disclosure, comprising 4,747 documents, including the witness statements and exhibits I referred to a moment ago. And to give those listening just a few examples of the disclosure made to date, it includes statements from organisations such as Dementia UK, members of the Disabled People's Organisations, the Welsh Government Care Forum Wales, the Older People's Commissioner for Wales. There is the results of the local government

survey of its member local authorities in England and Wales, and the findings, for example, on capacity and/or resilience in the adult social care sector. There are references in those survey findings to the highly negative impact that the pandemic had on unpaid carers.

The results of the Scottish survey are expected in the very near future.

I know that the Northern Irish Covid Bereaved Families for Justice make reference in their submissions to the absence of a similar survey in Northern Ireland, and they are correct.

As my Lady is aware, the structure of health and social care is very different in Northern Ireland and, given the integrated system of health and social care, local councils have no role in the provision or commissioning of adult social care, and so could not assist in such a survey.

It's partially for that reason that Rule 9 requests were sent to the health and social care trusts in Northern Ireland, who are in fact the bodies responsible for providing adult social care services in their areas of operation.

Given the amount of disclosure that is anticipated to be forthcoming, certainly in the imminent future, there will be further tranches of disclosure in the

coming weeks and months.

That disclosure brings me on to the third item on the agenda, and expert evidence. Before Christmas, the Inquiry disclosed draft expert reports in relation to three particular areas: the impact of the pandemic on end-of-life care, impact of the pandemic on those in adult social care with dementia, and the impact upon individuals with learning disabilities.

The Core Participants have provided their comments on those reports and the Inquiry anticipates disclosing the final version of the reports in the spring of this year. But it may assist your Ladyship to have a brief introduction to some of that expert evidence and the matters contained in those draft reports.

The dementia expert includes reference in his report to the fact that in 2019 there are approximately 885,000 people in the UK with the dementia, and that that was expected to have reached 1 million by last year.

In terms of mortality, in the pandemic people with dementia were disproportionately negatively affected. To give just one example, over a quarter of those who died of Covid in England and Wales between March and June of 2020 had dementia. It was about 13,840 deaths just in that few months period alone.

Professor Sube Banerjee's report examines the impact

of the pandemic on the care and treatment of people with dementia and their family carers, whether they were receiving in their own home or whether they were resident in a care home, and his report looks at the impact of mental health outcomes and mortality rates, and the impact of things like lockdown and visiting restrictions on people with dementia and, indeed, the impact of infection prevention and control measures on people with dementia.

The second expert report is that prepared by Professor Chris Hatton and Professor Richard Hastings, and it examines the impact of the pandemic on individuals with learning disabilities. That draft report notes that people with learning disabilities were more at risk of being infected, more like likely to be hospitalised, and were at higher risk of dying from Covid-19.

In addition, the pandemic negatively impacted family carers, particularly those caring for adults with profound and multiple learning disabilities and where the impact of the withdrawal of support services was most keenly felt.

The third expert report looks at palliative and end-of-life care, the impact of the pandemic on those in receipt of palliative care, which for the purposes of

the report, is defined as people with life-threatening illness and those at end of life, commonly considered to be within the last year of their lives, and often to those in the last months and weeks of their lives.

Importantly, the report notes that end-of-life care is not just about pain relief and other pharmacological treatments but is often about a more holistic approach, aimed at achieving the best quality of life for those patients and their families.

As Professor Katherine Sleeman and Professor Stephen Barclay explain, palliative and end-of-life care services are often interconnected across health and social care and throughout all care settings, and so their report not only examines palliative and end of life care in care homes and that provided by domiciliary social care providers in one's own home, but it does include some information about the services outside the scope of Module 6. So, for example, it does include reference to care provided by general practitioners, community nurses, palliative care specialists, and it includes references to settings that are outside the cope of Module 6, including care in hospices and the community.

The inclusion of that information, although outside of the scope, has been provided for important context,

in our submission. But it should not be taken to mean that the scope of Module 6 has been amended.

My Lady, I know that a number of Core Participants are likely to ask you this morning to consider instructing experts covering additional areas of evidence, that includes a request that Module 6 obtain expert evidence on the structure and capacity of the care sector in each country. Now, you may recall that at the first preliminary hearing that was an area of expert evidence that the Inquiry itself was considering but, in fact, it was not possible to identify a suitable expert who could cover the matters the Inquiry was interested in from a UK-wide perspective. Moreover, as in fact the evidence gathering process has progressed, evidence about the respective structures and capacity or lack thereof is, in fact, contained in a number of corporate witness statements and it's also contained in evidence from organisations such as the King's Fund, whose statement has been disclosed, and in statements provided by the Nuffield Trust and Social Care Institute for Excellence, or SCIE as they're often known, whose draft statements are in the process of being finalised.

Across the combination of all of that evidence, it is our submission that it is no longer necessary for you to seek expert evidence on that topic.

Other requests this morning are for you to seek expert evidence on the impact on people with physical impairments, people with sensory impairments and people with multiple or complex needs. Now, your Ladyship has already considered which conditions should be the subject of expert evidence and, doubtless, you could have picked many more or in fact differently but, in our submission, there comes a point where it's unrealistic and disproportionate to seek additional expert reports, and so this may be one of those difficult decisions where you decline this request. That same reasoning may apply to the requests made by the DPO Core Participant group that you consider the impact of the pandemic on people with cerebral palsy and autism.

There is a request that you consider instructing an expert in mental health to speak to the elevated risk of death among people with severe mental illness and, in particular, elevated risk of death for Black Caribbean and Black African people. In our submission, whilst no doubt important, you may consider that request lacks a sufficient focus on the scope of Module 6.

I know that you are also going to be asked this morning to consider an expert to consider the impact of racism, ageism and sexism as it relates to Module 6 and, in particular, an expert to speak to the

disproportionate impact of the pandemic on female carers, both unpaid and paid.

I know that you will recall from Module 2 that you received evidence from experts in relation to aging and ethnicity from Professor Nazroo, and indeed gender from Dr Clare Wenham and, in our submission, that evidence, coupled with the evidence gathered across Module 6, including the expert evidence that's being obtained, it is not necessary for you to seek additional expert evidence in this area.

May I turn, please, to item 4 on the agenda, which is the provisional list of issues.

In common with other modules, the Module 6 legal team has provided Core Participants with a list of issues, the list is provisional, it is not intended to be exhaustive, prescriptive, or indeed final. Inevitably, someone issues may come into greater or lesser focus as the module progresses, some may drop away, other issues may emerge. So it follows that not all of the areas will be addressed to the same degree or explored in the same way at the Inquiry's public hearing.

We are grateful for the suggested additions and amendments made by some of the Core Participants and will consider those as disclosure progresses and the

list of issues itself will be kept under review and an updated list will be circulated to Core Participants in due course.

The John's Campaign Core Participant group submit that Module 6 should examine the role played by insurers in adult social care sector, which may have led care homes to take what they describe as a "risk-averse approach". For example, in relation to visits, it is said that, even where leeway was provided by government guidance, some care homes took a more restrictive approach to visiting as a result of the insurer's stance.

Now, some of the statements obtained by Module 6 indeed refer to the insurer's position and so, to that extent, Module 6 is aware of this issue but, in our submission, it is beyond the scope of this module to seek additional evidence on this topic nor would it be proportionate to do so.

In relation to the list of issues, may I just say something about the extent to which pre-pandemic decisions and structure and capacity are being covered by Module 6. As you know, the Module 6 scope sets out that this is an examination into the structure of the care sector, the key bodies involved in the UK and devolved administrations at the start of and during the

pandemic. This includes, and I quote, "staffing levels and bed capacity immediately prior to the pandemic".

It is submitted on behalf of the Frontline Migrant Health Care Workers Group that Module 6 should look at the extent to which pre-existing issues, such as underfunding, understaffing, unavailability of sick pay, overrepresentation of insecure migrant workers should feature in Module 6 and, my Lady, you have already heard evidence about some of those matters and, indeed, a number of the statements provided to Module 6 include further reference to those concerns. Doubtless, you will take that background into account but there is, in our submission, a limit to the extent to which you need to further examine these matters.

As you have said before on a number of occasions, including on your ruling in this module, following the first preliminary hearing, it is not within your terms of reference to seek to address these long-standing and deep-rooted issues and, in our submission, the focus of this module's work must firmly remain on the impact of the pandemic itself.

My Lady, a brief update in relation to the listening exercise Every Story Matters. Work on Every Story Matters continues. There are thousands of care experiences being analysed for the Module 6 record and

it is anticipated that that will be disclosed to Core Participants in the spring of this year.

Finally, my Lady, a few words from me on the public hearing, and a word at the start about Module 6 approach to calling impact evidence.

As with the Inquiry's other modules, Module 6 will commence with an impact video. In addition to the ESM record, the expert reports and the surveys conducted on behalf of the Inquiry, many of the Rule 9 requests have asked the recipients for evidence of the impact of the pandemic on those in receipt and indeed providing adult social care. Some of that evidence will be called at the public hearings along with some impact evidence from each of the four Covid-19 bereaved groups.

In addition, the Inquiry will hear some impact evidence from people who provided adult social care, and the Inquiry wishes to explore calling a witness who was in receipt of social care. I am hopeful that with the assistance of the Inquiry's policy and research team, we are now actively pursuing the option of trying to identify a witness who was in receipt of social care, and, in particular, to call evidence from a witness who can attest firsthand to the impact of the pandemic on people with disabilities.

The hearing itself will commence on Monday, 30 June,

conclude on 31 July of 2025. I know that those representing the Covid Bereaved Families for Justice and indeed Northern Irish Covid Bereaved Families for Justice submit that you should extend the hearing time by an additional five weeks to allow what they submit should be sufficient time for all the issues to be examined and to allay any fears that the care sector might be treated with lesser priority than the NHS.

In our submission, even if it were possible to extend the hearing time, which it is not given the programme of work you have in 2025, it is not necessary to do so, as we submit that in the current hearing time there is sufficient time for you to consider all the matters within scope, not least because of the knowledge you have gained and the evidence you've heard from the other modules, which will enable you to bring a real focus, in our submission, to the key decisions affecting the social care sector.

My Lady, the Inquiry does not currently anticipate holding a further preliminary hearing for Module 6 before the start of public hearings. However, I know you will keep that under review and will inform all Core Participants if you consider a further preliminary hearing necessary.

Preparation for those hearings continues. We intend

to circulate a provisional list of witnesses and will invite Core Participants' submissions on those lists.

There will be, as I said a moment ago, a final draft of the list of issues and the monthly update notes provided by the Solicitor to the Inquiry will provide detail about the process for making written and oral submissions, the process for evidence proposals, and the Rule 10 procedure to be adopted by Module 6.

So my Lady, that concludes all the matters that I wish to raise. Can I invite you now to hear submissions from Mr Weatherby King's Counsel on behalf of Covid-19 Bereaved Families for Justice.

LADY HALLETT: Thank you very much indeed, Ms Carey.

Mr Weatherby.

Submissions on behalf of Covid-19 Bereaved Families for Justice by MR WEATHERBY KC

MR WEATHERBY: Thank you very much.

As set out in the Covid Bereaved Families for Justice UK Rule 9 statement of Jean Adamson, Module 6 is an extremely important module for the bereaved families. Many of our families lost loved ones who were either receiving residential or domiciliary care or were working in the care sector itself. They tell heartbreaking stories of the problems of receiving adequate care during the pandemic and not having been

able to visit loved ones.

Many of our bereaved families work in social care and many more are family carers. They come from all four nations and jurisdictions of the UK.

I will turn to each point on the agenda. Where we made repeat submissions on issues common to other modules, or where we know other advocates will address similar points we can adopt, I will do so, and I will move on swiftly.

So Rule 9 statements and evidence gathering. We are grateful for the updates and we note the number of Rule 9 requests for statements that have been sent out. As Ms Carey King's Counsel referred to earlier, in our written submissions we made submissions, which we hope were helpful, to a limited number of further witnesses whom we considered should be requested to provide statements. Obviously I'm not going to go through those now, but we have been and remain keen to liaise with your team about them and we are grateful that it's been indicated that those submissions have been and are being considered.

I emphasise we are not, of course, at this stage asking for those witnesses to be called, just that they appear to be able to provide evidence that isn't covered elsewhere.

I'll just give one example, because I'm aware that not everybody listening will have read the written submissions, but we have, for example, suggested Professor Christina Pagel, from Independent SAGE. Amongst other matters, we know that she can provide evidence of how the care sectors of a number of other European countries fared, which might assist the analysis of our own system, but more specifically it might help inform recommendations from this module.

So we are reassured by what's been said by Ms Carey this morning generally, and we look forward to liaising further about this issue.

We raise a particular concern that the devolved administrations are covered properly. Again, by way of example, the Age UK witness, Caroline Abrahams, notes that her organisation covers England and matters reserved to the UK centrally, but she indicates that colleagues from Wales, Scotland and Northern Ireland are better able to deal with their jurisdictions, and so we propose that the Inquiry should at least get Rule 9 statements from the age organisation in each of the three devolved administrations.

No doubt those requests can be tailored to limit duplication with Caroline Abrahams's, and obtaining the statements doesn't necessarily mean that they will need

to be called, of course.

I note that, on the subject of Rule 9s, Ms Campbell King's Counsel is going to make submissions specific to Northern Ireland, and also, importantly, regarding migrant workers. So I'm going to leave that, with respect, to her. And knowing what she's going to say, we adopt those submissions in advance and underline the importance of them.

Can I turn to the evidence that's been described as "on the ground"? And again, I note the helpful comments of Ms Carey this morning regarding evidence from individual care homes, and that's dealt with in paragraph 5 of the CTI note. And the reference is made to the sending of Rule 9s to a random selection of care homes, and I quote, "designed to obtain evidence from those 'on the ground'", in a way that we took to be similar to the spotlight approach in terms of hospitals.

We absolutely agree it's a good idea to obtain such example evidence from residential care and nursing homes. We would ask that it's extended to domiciliary care providers also.

Now, we've had the experience of Module 3 and the approach taken there, we would urge the Inquiry not to rely solely on the care home owners or operators, as appears to be the intention, but to engage with staff

and service user organisations and family members too.

The Inquiry will only get one perspective if it doesn't do that, which may be worse than not doing it at all, because it could be inadvertently misleading. And obtaining only the providers' view might illicit a partisan and institutionally defensive position, rather than one which truly does give an "on the ground" experience.

We fully understand the limitations of this sort of evidence, as noted by Ms Carey. Care home and care sector providers are even more disparate in nature than hospitals, and Ms Carey has referred to some of the characteristics of that: size and purpose, residential, nursing and care homes, domiciliary providers. And we would add that there are different purposes to those that support older people with semi-independent living, those caring with people with dementia or those with learning disabilities, and then, in addition to that, the respite and recuperation care.

And, of course, there are four jurisdictions, and private and public sectors. So truly a wide range of different providers and different sectors and locations.

From the evidence from our own families, we're acutely aware that some of the care facilities and providers performed to the highest possible standard,

and we set that out in paragraph 13 of our written submissions. But we are also acutely aware that others didn't.

And if the selection of care homes is at random, then that may lead, inadvertently, to a picture which isn't as clear as it might be. And therefore, we respectfully ask that there's a liaison between your team and the CPs as to exactly which providers are picked, so that there can be a representative sample.

Now, Ms Carey has added to what's been said in writing in what she said this morning, and it appears, and we are reassured, that there has been thinking along these lines already. We'd be keen to assist with that.

As we've said, being truly representative is impossible within the capacity of the Inquiry, but designing into the exercise a spread of different experience is essential, and we respectfully assert that we have relevant import into how to achieve that.

So, in our view, the Inquiry should liaise with CPs to ensure the diversity of the example of spotlighted facilities to achieve a spread, even though not a representative sample, of care homes for the reasons that Ms Carey has correctly already referred to.

Time is short for this to be done, but there's no reason why this type of approach can't be taken if acted

on expeditiously. We would respectfully say that a list should be finalised, narrative or position statements should be obtained from each, followed by very targeted Rule 9 requests to each stakeholder, and those stakeholders should include providers, staff and users.

Disclosure. We've highlighted our concerns regarding disclosure, and we've listened carefully this morning to Ms Carey. We fully understand the Inquiry is moving at pace. We understand that disclosure will continue throughout, even up to and beyond the start of hearings. However, it is hugely important to everyone that production of material is made to the Inquiry in proper time for it to be worked and acted upon, but also, in time for disclosure to Core Participants. The later material is produced to the Inquiry, the greater the chance of things being missed. The later it's disclosed to Core Participants, the less effective their participation can be.

I know that is stating the obvious, but it does bear repeating.

We note that, in this Inquiry, there have been times when material has been produced late and, again, Ms Carey has adverted to that this morning, and we understand that providers are under pressure from multiple module requests. We're not unsympathetic, but

processes take as long as they're allowed to take. For an Inquiry as important as this one, resources must be made available, particularly within government departments and state agencies. Furthermore, the longer evidence gathering takes, the more expensive the exercise, because delay reduces efficiency.

The consequences of late production to the Inquiry is late disclosure from the Inquiry to those who have a right not just to take part but to effective participation. With a large amount of disclosure made close to hearing dates, that makes things much more difficult. The problem is not confined to this module or, indeed, to this Inquiry, as we've set out in our written submissions with the example of the CQC at paragraph 15.

Referring to this, Ms Carey has helpfully indicated that the Inquiry is aware of these issues but we do note that, as of today, we've received only 26 witness statements, for example, which obviously are a key part of disclosure. So, as in other modules, we do repeat the submission that we've made before: that the Inquiry should set a date, not a deadline, but a date, and we've suggested two months prior to the start of the hearings, by which it intends to complete the substantial bulk of disclosure to Core Participants. By doing so, the

Inquiry can work back and use its considerable powers to require timely production of evidence, and only by doing so can we ensure that our families can effectively participate.

Just finally on disclosure, one specific point, and that's the local government surveys and the lack of such evidence from Northern Ireland. We note what Ms Carey has said and, once again, we know that Ms Campbell is going to address this, and we adopt what she is going to say in that regard.

Also, with respect to the local government surveys, we repeat what we said about the example evidence: that it's essential that the Inquiry seeks out evidence of staff and service users, as well as the perspective of provider and local authority.

Experts. We note the disclosure of the three expert reports, which has been very helpful. We provided our written observations on those, which we trust will be of assistance to the Inquiry.

In our written submissions we've raised issues of discrimination as they apply to Module 6 issues. They are as important, as issues in Module 6, as in any other module -- the issues of structural and institutional racism, affect the care of individuals and also staff. The disproportionate impact applies in Module 6 as in

other modules.

We note the earlier evidence and the fact that this module, of course, can rely on the early evidence relating to structural and institutional discrimination but, given the specific issues of Module 6, at least the Inquiry, in our submission, should seek addendum reports which speak to those specific issues in respect of the issues under Module 6.

Ms Campbell is going to address you on the need to commission an expert on the disproportionate impact of the pandemic on female carers, both paid and unpaid, and again, we adopt what she will say about that. Respectfully, we say that this is a significant lacuna in the evidence regarding this issue. We have also raised, as Ms Carey has noted, the discrete issue of the impact of the pandemic on those with mental ill health, and we pick up the comments that were initially made by CTI prior to the first preliminary hearing in their written note for that, and we have, in fact, put forward a suggested expert who can deal with the effects of mental ill health, and also the intersection evidence of mental health with black Caribbean and black African people, which is a particular concern.

Finally, just can I piggyback onto the issues of experts the issues of language. Our families have

raised with us specific concerns, which we've addressed at paragraph 25 of our written submissions, a number of families have raised an issue with the use of the term "carer burden", which has appeared in some of the disclosed material. For obvious reasons, perhaps and particularly with those bereaved, there's a strong feeling that the care of their loved ones should not be seen as a burden. "The impact of caring" would be a more appropriate phrase and, similarly, whilst on the same language, we'd urge the Inquiry to encourage witnesses to avoid terms such as "suffering from dementia", and to use more neutral terms, simply "people with dementia" would be more appropriate. Language is obviously important.

The list of issues we've dealt with at paragraph 26 of our submissions. It's a simple point, I hope. The outline of scope on the list of issues includes the structure of the care worker, as Ms Carey has said, including staffing and capacity, at the outset of the pandemic and, we say, by implication, planning. But the list of issues refers to the relevant period being the 1 March onwards. That would appear to downplay or indicate that there won't be evidence relating to what occurred in January or February 2020.

As we said in writing, the position at 1 January is

hugely important but, whatever you decide the state of the social care sector at that point, both January and February were crucial months for the genesis of the emergency response, both by the UK and the devolved administrations, by local authorities, by care providers. We've set out what the key issues were during that initial period in our written submissions: the urgent optimisation of capacity, planning for widespread testing, PPE procurement and distribution, isolation facilities, IPC guidance, addressing the movement of staff, clinicians, and the approach to visitors and visitation. All of this applies to residential facilities of all forms but also to domiciliary care.

Neglect of the care sector is a well-known feature and we've cited in the written submissions, from the disclosure itself that we've received so far, no less than eight organisations and institutions who have spoken to this issue. So the months January and February were key to how the previous neglect of the care sector became exposed and what was done about it.

We pointed out in the Rule 9 statement that the Health Secretary, Matt Hancock, didn't even know how many care homes there were in England, even by March 2020. There was no Director General of Adult

Social Care in the DHSC for the four years prior to the pandemic, and there was no adequate pandemic planning for the care sector or for specific issues, such as PPE and IPC.

That's why it's so important to us that the Inquiry looks at evidence right from the outset. Shockingly, finally on this topic, it appears that the adult social care sector is in little better shape to respond to the next pandemic five years on and it's, of course, vital that the Inquiry meets those key points for the purposes of recommendations.

Every Story Matters, I'm not going to repeat the same submissions we've made a number of times, save that I want to note two things: first of all, that the Inquiry has now had four modules in which it has heard the accounts of bereaved family members and it can be in no doubt as to how powerful that evidence is, adduced in such a way; and, secondly, the issues of care in Module 6 are particularly relevant for so many of our families. So to those ends, we submit that the Inquiry should call a greater number of bereaved family members who have different accounts to tell of their experiences of care during the pandemic. As we've done in other modules, we'll submit a schedule which we hope will be of assistance to the Inquiry.

Finally, in respect of hearings, again, we have made similar submissions in other modules, so I'll be brief. From the outset, we've urged the Inquiry to expedite its processes and complete its task as soon as reasonably possible. We respectfully commend it for moving swiftly from one module to the next. However, there must be a balance. Module 6 is currently listed for four weeks, during which we anticipate there will be 17 days for the hearing of evidence. That compares to 37 days of evidence in Module 3, health care and we submit, although they're very different modules, they are broadly comparable.

I don't repeat what we've said in writing but we have raised the fact that there are four systems across four nations and jurisdictions. There are numerous bodies involved across the UK, the devolved administrations, at local authority level. Secondly, there is a proliferation of guidance. Thirdly, there is the importance of treating the care sector as importantly as the health care systems.

So, in summary, we submit that the Inquiry should consider extending the time for the hearing of evidence. We fully understand the response that Ms Carey has given this morning, we do understand the need for any such extension to be proportionate but we would respectfully

ask you to think again about whether this a module that can be properly dealt with in 17 days of evidence.

My Lady, those are our submissions, unless there is anything I can assist you with further.

LADY HALLETT: No. Thank you very much for your help, Mr Weatherby.

Ms Campbell?

Submissions on behalf of Northern Ireland Covid-19 Bereaved Families for Justice by MS CAMPBELL KC

MS CAMPBELL: Thank you, my Lady. I hope you can see and hear me.

Can you hear me?

LADY HALLETT: Distantly.

MS CAMPBELL: Shall I move the microphone. Does that help? Shall I get started and see how we go?

LADY HALLETT: Yes. Thank you.

MS CAMPBELL: Thank you.

My Lady, good morning. Can I start by adopting the submissions that Mr Weatherby has just made on behalf of the UK Covid Bereaved Families for Justice. As ever, we are grateful to him for the issues that he has advanced on our behalf and jointly.

My Lady, on behalf of the Northern Ireland Covid Bereaved, you really don't need to hear from me about the importance of this module to the Northern Irish

Covid bereaved because you have heard it directly from so many in our group on more than one occasion.

You know, because you have heard it, that providing a high standard of care, be it social care, residential care, nursing care, domiciliary care or care from family and friends --

LADY HALLETT: I can't hear you at all at the moment.

MS CAMPBELL: Well, we've got the microphone working here. Can you hear me? No.

MS CAREY: I don't know if your Ladyship is going to hear me speaking. You can hear me.

LADY HALLETT: I can hear you.

MS CAREY: Would it be sensible for Ms Campbell perhaps to stand where I am, if we can't remedy the problem? Would you just give us one moment to rearrange ourselves? Thank you very much.

MS CAMPBELL: Can you hear me now?

LADY HALLETT: I can, thank you.

MS CAMPBELL: My Lady, I'll start again by saying that you don't need to hear from me about the importance of Module 6 to the Northern Irish Covid bereaved because you have so often spoken to members of our group who have reinforced that to you, and you also know from speaking to members of our group that providing the highest possible standard of care, whether it be social

care, domiciliary care, residential or nursing care, or care at home from family and friends, really matters in Northern Ireland. So determined are we that our loved ones receive the highest possible standard of care, that as a society, you know that we are prepared to shoulder 80% of the responsibility for it directly upon unpaid shoulders.

My Lady, we didn't need a pandemic to know that the Northern Ireland care sector was failing those that needed it. Instead, when the pandemic did arrive, you have heard, and will continue to hear, that people instinctively knew that reliance on the adult care sector, far from safeguarding their loved ones, increased their risk and vulnerability. That was true at every stage of the pandemic, from early 2020, when Brenda Doherty's mother, Ruth, passed away in a care home in March; for the brothers, James and Robbie Gallagher, residents of the same care home who contracted Covid in summer 2020; for William Creen who was housebound and reliant on domiciliary care and yet caught Covid in February 2021; for Raymond McAleese, who lived with Down syndrome and died from Covid that he contracted in the residential home in which he lived in December 2021.

There are too many more families who did everything

they could to navigate the broken and fragmented adult social care system, only to finding them and their loved ones powerless and trapped in a system that was overwhelmed.

My Lady, it's important that I acknowledge that the responsibility to protect the vulnerable so-called service users weighed heavily on many care home staff and domiciliary staff and others, and we support the submissions that you will hear this morning and will read in writing from all of those Core Participants who urge you to hear a range of voices from frontline staff, including from frontline staff in Northern Ireland. If you look, you will find examples of clear heroism and real compassion from the staff who cared for those reliant on social care and who supported their families beyond the call of duty.

But you will also find too many examples of isolation, neglect, disempowerment, overreliance on medication, misapplication of DNACPRs and a failure to consider the catastrophic consequences of hastily made decisions about hospital discharge.

You've heard the beginnings of that evidence from Marion Reynolds in Module 2C, from Eddie Lynch, the Commissioner for Older People of Northern Ireland, also in Module 2C, but we urge you to hear it very much from

a Northern Irish perspective in this module also, which really brings me to my first substantive submission.

We acknowledge that the Inquiry has sought evidence from a range of individuals and agencies in the north and we respectfully suggest that those requests do not yet go far enough. It is welcome news this morning to hear from Ms Carey that the Chief Social Worker, from whom the Inquiry heard Professor McArdle explain in Module 3, worked closely on issues around guidance and safeguarding, and it's welcome to know that a statement will be received.

We echo Mr Weatherby's submissions that you've just heard in relation to approaching Age NI directly, rather than reliant on the UK, if you like, umbrella organisation. We note and support the submission from the Disabled People's Organisations to obtain evidence from the Centre for Independent Living in Northern Ireland, who will doubtless be in a position to assist from their unique perspective. But, my Lady, it will be important that the Northern Ireland Rule 9 statements properly reflect that the very significant proportion, particularly of registered care homes in Northern Ireland, are privately managed.

Now, we don't have the Rule 9 statements that have been issued. We anticipate that, to some extent, the

fact that such a large proportion, 90% of privately managed, will be addressed within them. But, in real terms, the privatisation of the adult social care sector means that, for the most part, our loved ones in reinsurance care are also in profit-making businesses.

There are some very large providers in Northern Ireland who run multiple care homes and we invite the Inquiry to consider the consequences, both positive and negative, of that in the context of a pandemic.

Some of those privately-operated care homes, in the experience of our client group, appeared to develop and follow their own guidance or frameworks, despite all of the engagement and government assistance they received.

We will, of course, consider with care the disclosure still to come, including that from the respective trusts, which is a welcome alternative to the results, for example, of the local government surveys in England but, if the Inquiry hasn't already, it should consider approaching some of the smaller and larger private providers in the sector in Northern Ireland and we, of course, are in a position to assist.

My Lady, my second, albeit related request, is to focus on the position of black, Asian and minority ethnic migrant workers, particularly in Northern Ireland.

You have heard, and I know you found it disconcerting, my Lady, that there is a real lack of data collection in Northern Ireland, particularly when it comes to the position of black, Asian and Minority Ethnic community members and our migrant community. And there is, therefore, a difficulty in analysing -- firstly, in identifying, and, secondly, analysing -- their experiences during the pandemic.

We know that our care sector relies heavily on care workers from our migrant communities, but the lack of available or easily accessible data does not preclude this Inquiry from really trying, and trying hard, to capture their voices and experiences, and we urge you to do so to seek out that evidence.

There are organisations who can assist, the Migrant Centre Northern Ireland, for example, is one, and we can assist in identifying others, but not hearing adequate voices from migrant workers and, in particular, migrant workers from Northern Ireland, at any point in this Inquiry would leave us all the poorer, and in Module 6, perhaps more than any other module, their experience matters, and again, we are ready to assist.

My Lady, my third request is relating to expert evidence, and I won't repeat the statistics quoted at paragraph 6 of our joint submission, some of which are

truly shocking.

You heard evidence in Module 4, which has just finished, that there were an estimated 220,000 unpaid carers in Northern Ireland. To put it another way, one in eight people in the north has unpaid and unregistered caring responsibilities, saving the Department of Health a colossal 80% of its entire annual budget.

And my Lady, I anticipate that you know, and I know, and the Northern Ireland Covid Bereaved know, that the very significant majority of those 220,000 carers are women. Wives, mothers, daughters, sisters, nieces.

We have listened carefully, of course, to Ms Carey's submissions to you this morning, but we nonetheless urge you to obtain expert evidence on the disproportionate impact of the pandemic on women carers of all descriptions.

This is not, we submit, to use Ms Carey's words, a disproportionate or unrealistic request, given that we have, of course until July.

You may consider that you already have an expert, and inviting her to further contribute her expertise to this module is an important and indeed proportionate request.

The first paragraph of your draft outline of scope for Module 6 reflects your undertaking to consider

firstly the impact of the pandemic on people's experiences of the care sector, focusing on recipients of care and their loved ones and those working within the care sector, and, I quote, it will include "consideration of unequal impact" upon them.

This is a very clear area of unequal impact. And in furtherance, therefore, of your aim in your outline of scope, we urge you to really build upon the green shoots of evidence that have emerged in other modules, that the disproportionate responsibility borne by women in the care sector, both paid and unpaid, exacerbates gender inequality and amounts to discrimination against women.

And that discrimination, we know, impacts in real time: those who work in undervalued and low-paid jobs, those who give up employed work or reduce their hours to plug a gap in care that their loved ones needs but otherwise cannot access. It has long-term consequences on women's education, career and employment opportunities, pension contributions, and their health, and it is not unique to the experiences of women in Northern Ireland.

Although the value of unpaid work has grown exponentially in Northern Ireland over the last decade, there has been a sharp upward trend also in England and in Wales and, we anticipate, Scotland too. And

therefore, we invite you to consider the consequences of that in any future pandemic, and to seek expert evidence insistence.

My Lady, moving on to spotlight evidence. Mr Weatherby has, of course, already addressed this, but can we add just briefly from a Northern Irish perspective that it has been a remarkable feature of the evidence that you have heard from the bereaved and other groups across each module of this Inquiry, whether it be from the witness box or from the powerful impact videos, that all too often they could see where the mistakes were being made at the time they were being made. Individually and collectively, they voiced their concerns, they wrote letters, they spoke to the powers that be to tell them that they weren't seeing or appreciating the full picture and therefore changes needed to be implemented.

And yet, too often, their real experiences were given inadequate consideration.

We note, on the topic of spotlight homes, or evidence being chosen at random, that the concerns of the Northern Irish Bereaved about this approach are independently shared by the UK Covid Bereaved, by John's Campaign, we anticipate by the Disabled People's Organisations, and others, and we ask you to give proper

consideration to the concerns that are raised at this stage., because they arise not out of a desire to add to the work of your Inquiry, which we know is massive, but to enhance the evidence of this module by ensuring that, so far as possible, you receive a wide and adequately representative picture, and therefore, the recommendations that you will ultimately make are well founded.

And finally my Lady, on the subject of representative evidence, we of course endorse the concerns about the length of Module 6 as we also recognise the pressures that are upon this Inquiry. We would, of course, like more time to consider the importance of the issues before you in this module, but, anticipating that that may not be possible, on behalf of the Northern Ireland Covid Bereaved, may we push for a proportionate amount of time to be given firstly to the experiences of the bereaved, of patient groups, of other service users, and to that extent we endorse the submission in John's Campaign to hear evidence from the rights of residents and those at the coalface.

And, secondly, we urge a proportionate amount of time to be given to the evidence considering the response of the health care and social care sector in Northern Ireland, so that meaningful, focused and

Northern Irish-specific recommendations can be made for a more positive future. Thank you.

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

Ms Mitchell, would you like to take us up to the break? I hope your microphone is going to work.

DR MITCHELL: Can my Lady hear me?

LADY HALLETT: I can.

Submissions on behalf of Scottish Covid Bereaved by DR MITCHELL KC

DR MITCHELL: Fantastic. The Scottish Covid bereaved are grateful to Counsel to the Inquiry for her note and submissions this morning and also for engaging in discussions about matters which are of particular importance for the group.

This module, of course, is of particular importance to those who lost loved ones that died in care homes and in hospitals. As was set out in the first preliminary hearing, the bereaved are anxious to know why certain decisions were taken by the UK and Scottish Governments, whether they had in mind their human rights and whether those decisions impacted on, or indeed led, to the deaths of their loved ones.

Amongst other issues, many are waiting on the answer to a question that has been asked since March 2020: why

were those suffering from Covid transferred into care homes without being tested?

In this PH, we address the following four issues:

1. Rule 9 requests. The bereaved welcome the Inquiry's intention to issue Rule 9 requests to care homes and note the caveats attached to this evidence as outlined this morning. While the requests are to be sent to care homes located in both urban and rural settings across the UK, the Scottish Covid Bereaved hope that the Inquiry team will be able to recognise Scotland's distinct geographical features with many living in island communities. These communities and the care homes in them will doubtless have experienced issues which did not arise in mainland care homes.

It's hoped that the Inquiry legal team will be able to identify a care home in an island community, and that can be issued with a Rule 9 request.

2. Disclosure to Core Participants. We echo what has been said earlier, of course. We note that the Inquiry is doing what it can to get disclosure as soon as possible, and we are keen to receive that.

In particular, the Scottish Covid Bereaved note that the summary findings of the survey of local government, LGA, and the bereaved, are keen to see the results of the COSLA survey, due, as we understand it, in spring.

It would be surprising if the results of the COSLA survey differed greatly from that already obtained by the LGA. It's the experience of the Scottish Covid Bereaved that social care was poorly prioritised with insufficient numbers of staff to provide proper care.

Visits by health care professionals were restricted and, as outlined above, residents were discharged from hospitals to care homes without having been tested. The bereaved anticipate seeing their own experience reflected in the COSLA survey and look forward to additional disclosure soon.

3. List of issues. The Scottish Covid Bereaved are in a unique position in that we have an ongoing Inquiry in Scotland. It would be helpful to know what, if any, tens are being taken in relation to what evidence is to be called in this hearing, and the Scottish hearing to come, bearing in mind the memorandum of agreement that is in place. It is the hope of the Scottish Covid Bereaved simply to try to avoid duplication of questions being asked or requests for witnesses to be called.

The bereaved welcome the Inquiry's focus on decisions relating to the discharge of people from hospital into adult care and issues relating to visiting restrictions and guidance. In addition to aforementioned issues, the bereaved include those who

experience loved ones not receiving the care that they deserve, with GPs refusing to attend care homes and residents not being admitted to hospital.

It is hoped that these and other matters will be explored during the hearing. It is hoped that the Inquiry will also consider the impact of visiting restrictions on the residents themselves, particularly those suffering from dementia, and we look forward to reading the expert report in that regard.

4. Public hearing. The Scottish Covid Bereaved thank the Inquiry for its request as to input as to how witnesses can provide evidence of the impact of the pandemic for those in receipt of adult social care. We consider the best way for the Inquiry to hear impact evidence is to adapt the approach adopted in relation to Module 3, where members of the Scottish Covid Bereaved gave evidence to the issues faced by the group as a generality, with later evidence from a particular member with significant aspects to their loved one's experience that allows the Inquiry to hear specific impacts.

It's said that society is defined by the way it treats its most vulnerable and there is considerable evidence available that the most vulnerable, who should have been given the greatest levels of care, did not

receive that care when they needed it the most. Accordingly, the Inquiry may wish to consider allowing a greater number of impact witnesses from the bereaved groups to allow the Chair to have the opportunity to hear directly about the plight of those most vulnerable?

The Scottish Covid Bereaved have always been measured in requesting impact evidence, but submit that having two witnesses to speak to their own personal experience, one of whom can perhaps provide the general Core Participant witness statement and can have additional specific questions put to them at the same time as giving their own personal account.

The Scottish Covid Bereaved are aware of the effect of calling a number of additional witnesses and the impact this may have on the Inquiry's timetable, especially when this is multiplied over all the bereaved groups but we submit that allowing an extra few hours for this purpose may be of significant value.

It is noted that the media pick up on and highlight individual stories in a way that they do not for more general issues, unless of course the politicians are involved. Greater public awareness of the issues faced by those most vulnerable in society may ultimately result in greater public support for the recommendations which the Chair will ultimately make. The Scottish

Covid Bereaved have noted the chair's comments that she can make recommendations but it is for the politicians to implement them.

It is submitted that the broader the public support, the greater the public pressure and the more likely implementation of those recommendations. Those may be assisted by hearing more directly from those who either lost the most vulnerable or were the most vulnerable.

These are the submissions of the Scottish Covid Bereaved.

LADY HALLETT: Thank you very much indeed, Ms Mitchell. Extremely grateful to you.

Very well, we shall take the break now and I shall return at 11.55 am.

(11.40 am)

(A short break)

(11.55 am)

MS CAREY: My Lady, I hope we're turning next to Mr Stanton.

LADY HALLETT: We are.

Yes, please, Mr Stanton.

MR STANTON: My Lady, I hope you can hear me?

LADY HALLETT: I can. Thank you.

Submissions on behalf of the Covid-19 Bereaved Families for Justice Cymru by MR STANTON

MR STANTON: Thank you.

My Lady, on behalf of the Covid-19 Bereaved Families for Justice Cymru, there are four points that I'd like to make.

The first is a point that's already been made by Mr Weatherby and Ms Campbell, that this module is one of the most important for the group, and, for many of the group members, it is the most significant of all modules at your Inquiry.

It will also be one of the most difficult for the members to participate in, having regard to the devastating impacts of the circumstances under investigation.

My Lady, we know that you are acutely aware of this, but it is a fact that cannot be understated, in our submission.

The next point, my Lady, relates to the cross-cutting nature of Module 6. By the time you hear evidence in this module, you will have heard evidence in nine previous modules, all of which will have included evidence that is relevant to care homes, including issues of testing, asymptomatic and aerosol transmission, PPE, key government decisions such as whether to discharge patients from hospital without testing.

If I could give a Wales-specific example of these

cross-cutting issues, my Lady, you heard in Module 2B from the former First Minister of Wales, Mark Drakeford, that there is no or was no single register within Wales of all care homes.

You also have heard in previous modules, and you will hear in Module 5, that the responsibility for provision of PPE to care homes fell to the Welsh Government from 19 March 2020.

My Lady, added to this, the group has proposed a witness, a former health care owner, former nurse and health care owner, who, if the request for a witness statement is pursued, will be able to provide evidence that no PPE whatsoever was provided to her care home until late April 2020, early May 2020, and that in a briefing in March 2020 care homes were advised to seek their PPE from pharmacies.

You will of course have heard, my Lady, in Module 3 that pharmacies were one of the last health care settings to receive any PPE, so that route was completely blocked to them.

So, pulling all these strands together from the various different modules that you have heard and will hear in the future, the group would like to know, and invite the Inquiry to explore, the state of provision of PPE in relation to care homes within Wales, and also to

ask the Welsh Government to explain, particularly given they didn't know of the existence of every care home in Wales, how they were able to meet their responsibilities.

So that's just one example. There are many more, and there will be many different examples, including examples relating to testing.

My Lady, the Welsh group would invite you in these circumstances to consider asking Core Participants, particularly Core Participants who have participated in many previous modules, to assist the Inquiry by highlighting issues such as this, so that the Inquiry can ensure that they are fully explored, that the evidence needed will be available in Module 6, and so that these issues can be addressed within witness statements in the preparatory stages of the Inquiry's work.

My Lady, we appreciate that the Inquiry will be well aware that cross-cutting issues such as these exist, but we suggest that the particular interests of each Core Participant group can add value to this exercise. We appreciate there's a need not to over-engineer any work such as this, but on behalf of the Welsh group, my Lady, we would not anticipate -- if you were able to allow this opportunity, we would not anticipate raising more

than ten such issues. So we think it's a proportionate and manageable option.

One connected issue to this, my Lady, relates to the period of time specified in the list of issues that the Inquiry will be focusing on, which suggests that that period will commence on 1 March 2020.

My Lady, for the reasons mentioned, we'd ask that the Inquiry gives consideration to relaxing that date, so that, for example, issues of preparedness and resilience, as were considered in Module 1, can also be considered in Module 6.

My Lady, moving to the next topic, that is the group's priorities and key witnesses. My Lady, the group's priorities are set out in the group's witness statement and within the written submissions provided for this hearing. I don't seek to repeat those issues now. I would like, however, to mention an issue in relation to witnesses.

My Lady, in Wales, to an extraordinary degree, key decisions for consideration by the Inquiry on issues such as testing strategies in care homes, again, the decision not to test patients being discharged from hospital, provision of PPE, and the extent to which treatment was withheld or not provided in care homes, were taken by a very small number of key

decision makers, including the former First Minister, Mark Drakeford, the former Minister for Health and Social Services, Vaughan Gething, and the CMO for Wales, Sir Frank Atherton. And we would be grateful if the Inquiry would give careful consideration to calling all three witnesses in the Module 6 hearings.

My Lady, the final topic I'd like to deal with is impact evidence. As already mentioned, the issues under consideration in Module 6 are particularly distressing for bereaved families, with some care homes having lost over half of their residents, and there are a very wide range of impacts that were experienced by the families of residents.

The group suggests in these circumstances that there is need for more than a single group statement that collects and reflects a range of experiences, and we have been grateful for the Inquiry's invitation to speak to these issues.

We consider that the process that was followed in Module 3 was a good one, whereby health care organisations were invited to provide biographies for between five and ten members, from which witness statements were selected for a smaller number, and then a still further smaller number were asked to provide evidence, and that type of process we think could be

adopted effectively here in Module 6.

One concern we would have, however, would be in any selection process. For example, if biographies were provided by families, there would be a risk, if they were not selected for witness statements, for it to be seen as somehow their story was not considered sufficiently important or significant, and therefore, to avoid that real risk and possibility, we would suggest that the Inquiry considers inviting witness statements from between ten to fifteen families within each of the bereaved groups and other similar groups. These would be statements that, we suggest, could be proportionate, and the length would be manageable, either with reference to page numbers or, indeed, the amount of time to be spent on them. But we think it will be an important signal of the importance of their experiences to proceed in that way.

My Lady, one final point I'd like to make very quickly is a point addressed earlier by Mr Weatherby in relation to Age UK.

Age UK is primarily focused on England and we would ask in those circumstances that the Inquiry gives consideration to requesting a witness statement from Age Cymru.

My Lady, those are all the submissions I would like

to make, unless I can assist further.

LADY HALLETT: No, thank you very much indeed, Mr Stanton.

Right, now I think it's Ms Irving for Disabled People's Organisations.

MS IRVING: My Lady, can you hear me clearly?

LADY HALLETT: I can. Thank you.

Submissions on behalf of Disabled People's Organisations by MS IRVING

MS IRVING: I'm grateful.

My Lady, we act for four Disabled People's Organisations from across the UK. They are: Disability Rights UK, Inclusion Scotland, Disability Wales and Disability Action Northern Ireland.

The DPO reiterate the importance of this module to them and the people they work with. Within the care sector, disabled people suffered significant and disproportionate fatalities and other harms during the pandemic. For many disabled people, the impact on their lives is ongoing.

The DPO have four points. First, as to settings. From my Lady's previous ruling, DPO understand that the primary focus of this module will be on adult care and residential homes and care provided in the home. They nevertheless welcome the recognition of the need to consider the impact of the pandemic on additional groups

of people in receipt of social care, including those with learning disabilities.

In doing so, you have recognised that recipients of care can live in a range of supported forms of housing.

The Inquiry's careful widening of the lens in this way is important. It ensures that variations in where and how disabled people live are appreciated and factored into overall learning. This could include in supported housing, mental health units, and various forms of transitional accommodation.

We note that there is no broadly applicable statutory definition of supported housing, but the Ministry of Housing, Communities and Local Government define it as "accommodation provided alongside support, supervision, or care, to help people live as independently as possible in the community".

Even for those who live at home, their ability to do so can often depend on access to respite and day centres and other social care in the community. Each of these settings and services is indispensable to certain groups of disabled people to lead dignified and independent lives.

As settings and services, they were also profoundly impacted during the pandemic. For those reasons, in accordance with my Lady's ruling and the terms of

reference for this Inquiry, DPO do not seek a full audit of these matters, but it is important that they are included in the investigation.

To that end, and bearing in mind what Counsel to the Inquiry has said this morning, the DPO in their written submissions have made suggestions of other cohorts that the Inquiry might consider. The purpose of these suggestions is to assist in building a picture of the Social Care Sector, and those other cohorts of people with cerebral palsy and autistic people.

Our second point falls within paragraph 1 of the Inquiry's preliminary list of issues for this module, and it concerns the reduced adult social care support during the pandemic.

In three of the four UK nations, one of the first decisions taken was to permit statutory easements to social care duties. This enabled local authorities to cease formal social care assessments and reviews, and reduce provision without breaking the law.

Where easements were triggered by a local authority, the safeguards accompanying them were limited and ineffectual. For example, in England, although authorities were still required to meet a person's human rights at a minimum, in practice this meant the care user, in order to obtain relief, would have to access

legal representation, go to court, and prove that any reduction in services met the very high threshold of inhuman and degrading treatment.

We know from the Supreme Court decision of McDonald v Royal Borough of Kensington and Chelsea just how high that threshold is. It was not met where services were cut which required a disabled person to sleep with incontinence pads when she would not have needed them if she had a care worker to assist her.

Accordingly, from the outset, of the pandemic, the rights of disabled people to have their needs met were actively reduced by statute. As well as the significant practical consequences of this, the symbolic impact of this decision, what it said about the value placed on disabled people's lives, cannot be overstated.

However, it is the consequences of this legislation, including the transparency and monitoring of decisions made under it, that DPO submit requires consideration.

The statutory changes were introduced with minimal debate and process. For those local authorities that registered easements, and there were only eight of them, and just in England, there were no follow-up systems to disclose how or whether they were used, and no external monitoring of their effect.

That easements were not formally relied upon

elsewhere in the UK did not mean all was well. Social care users in areas that did not trigger easements also experienced significant reductions in their care and support, even to levels below what was previously considered the minimum acceptable. In many instances, this left people with their most basic needs unmet.

A University of Manchester-led study has since found that there was confusion across local authorities as to what social care changes should be made without triggering easements. The DPO therefore invite the Inquiry to scrutinise both the central government decision to introduce social care easements in three of the four nations, and the reductions and changes to social care provision made, both in areas where easements were triggered and those where they were not.

Given the removal and downgrading of the central services that undoubtedly occurred during the pandemic, some of which never returned, it is important to discover whether reductions were sufficiently proportionate, transparent, or consulted upon, including with DPO, and externally monitored.

Thirdly, the DPO welcome the Inquiry's intention to consider the use of do not attempt cardiopulmonary resuscitation orders in Module 6.

Adult social care users were at the sharp end of the

misuse of DNACPRs during the pandemic. According to the Care Quality Commission, from March to December 2020, there was a marked increase in the number of people with DNACPRs in the adult social care settings and nursing homes, despite there being no guidance suggesting that their use should increase.

Module 6 affords an important opportunity to address unanswered questions as to the misuse of DNACPRs, and understand what work has been done and what remains to be done to prevent misuse in any future pandemic.

In particular, DPO invite the Inquiry in its Rule 9 request to the Department of Health and Social Care to seek an explanation of why the Ministerial Oversight Group, established in response to the CQC's recommendations, met only four times, with the last meeting convened in May 2022.

Finally, the DPO invite the Inquiry to confront the pandemic mortality rates for people receiving care in their homes. By May 2021, at least 28,000 people in receipt of domiciliary care had died in their homes across England and Scotland. In the earlier stages of the pandemic, from March to June 2020, that was a 225% increase in mortality amongst those receiving care in their homes. That was a greater increase in mortality, in proportionate terms, than that amongst care home

residents. The reasons for this are not yet well understood. There has rightly been major public concern about deaths in residential care settings. Factors contributing to deaths of those receiving care at home should also be carefully focused upon in this module.

Of the various factors, my Lady has already indicated at previous hearing that the movement of care workers between different settings will fall within scope and, in that regard, we have in mind the inadequate financial support provided to peripatetic workers to self-isolate.

Last month, in the context of Module 4, the Inquiry heard evidence about the extent to which care in the domiciliary context was arguably even more misunderstood and overlooked than the fragmented and confused situation in care homes. Further, one particularly complicating factor for care at home is that, by the governing regulations, there is no obligation to report a death to the CQC unless a person dies while a regulated activity is being provided or is as a result of that activity. This means that the available data omits many deaths, including deaths of people receiving care from unpaid carers.

The DPO therefore invite the Inquiry to explore the important issue of deaths amongst those receiving

domiciliary care in its Rule 9 requests. In particular, the CQC must address the available data, the limits of that data and the reasons for this, and what, if anything, is understood by why so many recipients of domiciliary care died.

Finally, we again acknowledge the evident commitment that your Ladyship and your team, including Ms Carey QC, have shown today to that is module.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Irving. Very grateful.

I think next is Ms Jones for John's Campaign.

Submissions on behalf of John's Campaign, Care Rights UK and the Patients Association by MS JONES

MS JONES: Yes, my Lady -- can you hear me?

LADY HALLETT: I can, thank you.

MS JONES: Thank you, my Lady, on behalf of John's Campaign, Care Rights UK and the Patients Association, I plan to address three broad themes today, amplifying issues we've identified in our written submissions and which we hope will inform the Inquiry's conduct of Module 6 going forward.

Our first theme is the need for a close focus in this module on the dignity and quality of life of people who rely on care. Decision makers during the pandemic

often seem to overlook the fact that people living in residential care settings remain loved and valued members of families and friendship groups, and that they are not all one type of person. Their needs, characteristics and vulnerability to Covid-19 were individual and varied.

As my Lady well knows, human rights legislation already requires individual assessments of need, for example in this context, whether the harm of isolation and confinement outweighed the risk of Covid-19 for any particular person.

But in the experience of our Core Participant group, these obligations were consistently ignored and difficult to enforce, with John's Campaign having to bring judicial review challenges as late as mid-2021, to get the government to recognise these duties in the guidance it published for residential care settings.

My Lady, for the Inquiry to avoid repeating this mistake, it needs to hear the voices of those who draw on care and we welcome the Inquiry's indication that it is exploring how to achieve this. Our group stands ready to give oral evidence themselves in Module 6 and can identify to the Inquiry a number of other potential witnesses, including, as we have done, the grassroots organisation, Rights for Residents, as well as family

carers and people who rely on care, who will be able to testify to the direct impact of the restrictions imposed on them and the avoidable harm that was caused.

My Lady, we will follow up with the Inquiry after this hearing about these potential witnesses and our Core Participant group continue to encourage their supporters to share experiences with Every Story Matters, so that a broad range of personal experiences are heard by the Inquiry.

The day-to-day experiences of people who rely on care, their family members and care staff will cast an important light on the extent to which respect for individual dignity and concern for qualified of life informed the approach taken to the adult social care sector. There will no doubt be substantial evidence in this module on the high number of deaths among people in care homes and who rely on social care in other settings. This is, of course, important evidence from which we hope lessons can be learned, but we take this opportunity, my Lady, to remind the Inquiry that it is not only that people died but also how they died that matters, and their quality of life before they died.

To understand this involves understanding a broad range of issues, including the impact of restrictions, isolation and confinement, the loneliness and confusion

that were suffered by many people who rely on social care, the difficulties that people faced in accessing high quality health care, palliative care and end-of-life care when they needed it, and whether their loved ones were able to present with them in their final days.

The quality of life of people drawing on care was also impacted by whether appropriate measures were in place to ensure oversight and safeguarding in care settings, and this was particularly important when loved ones were excluded and inspections suspended so that the eyes and ears which ensure safe care were reduced, and, my Lady, whether there were adequate systems in place to deals with complaints and concerns about poor care when they were received.

The evidence that the Inquiry obtained in this module needs to be broad enough to address all of these points.

Through all of this, and to maintain the close focus on dignity that we say is so crucial to the conduct of Module 6, we urge the Inquiry to remember that decisions about care homes and other social care settings were not just decisions about institutions: they were decisions about the people for whom these settings are their home. We invite you, my Lady, to consider whether decisions

about them were made with the same care, caution and respect as decisions that were made about individual homes and the general population.

In this regard, my Lady, we repeat our request that the Inquiry obtains evidence in this module from Boris Johnson, who, as Prime Minister, was ultimately responsible for government decisions affecting the adult social care sector. His reported comments about the care sector and about older and disabled people, including, for example, blaming the high number of deaths in care homes on the care providers and describing the virus as "nature's way of dealing with old people", caused grave concern about the level of care and respect that underpinned government decision making for the adult social care sector.

Mr Johnson should, we say, be asked to provide evidence, including oral evidence, at the Module 6 hearings to explain how his decisions affecting the care sector were made and the extent to which the impact of measures of people who rely on care was ever taken into account.

My Lady, these are important matters within the scope of Module 6, Mr Johnson is uniquely well placed to address them and they were not covered by his previous evidence to the Inquiry.

Moving on to my second theme, which is the diversity of the adult social care sector and the need for the evidence obtained in Module 6 to reflect this.

My Lady, we welcome the ways in which the Inquiry has already recognised this diversity and variety, for example in expansion of the provisional scope to include domiciliary care and to take account of the experiences of unpaid carers, but we say that there is more to be done.

On unpaid carers, my Lady knows that the contribution made by unpaid carers to the adult social care system is enormous, and it's been touched on by other Core Participants this morning.

Even more than normal during the pandemic, unpaid carers stepped up to fill the gaps that arose and to ensure that their loved ones continued to receive the care that they needed. But in order to understand their contribution, their experiences and the impact on them, much more data is necessary.

There is, for example, no comprehensive register of unpaid or family carers, many of whom do not even describe themselves as carers, even though they do much more than would normally be the case, for example, for a spouse, parent, child or sibling. And as a consequence, many of them perform their role with

little or no targeted support.

Given the evidence that we know there is of the impact that increased caring responsibilities can have on family carers' health and wellbeing, and the extent to which this was exacerbated during the pandemic, this is something that we say needs to be remedied, and we seek the Inquiry's engagement with this issue.

On the diversity of care settings, we strongly urge the Inquiry, as the DPOs have also just done, to include consideration of supported and assisted living facilities and mental health units, which together comprise an important subsection of the adult social care sector, in which thousands of adults with, for example, autism, learning disabilities, and dementia live. These settings were subject to their own restrictions and government guidance during the pandemic, and they warrant their own evidence and conclusions.

The issues they raise are different from, but connected to, the issues observed in residential care homes, and if they are not considered in the course of Module 6, they will be overlooked by this Inquiry entirely.

My Lady, the importance of recognising the variety and diversity of care settings, particularly in the

spotlight setting exercise, is a point also raised by the Covid Bereaved groups, and in particular by Mr Weatherby King's Counsel this morning.

We endorse the points that they have made today, including on the length of the hearing for Module 6, and on the importance of understanding the position of the care sector in January and February 2020, not just from March onwards, and, in particular, in relation to the spotlight settings, on the need for the spotlight evidence to include the experiences of those who rely on care at the spotlight settings, rather than just the management perspective.

We are grateful for Ms Carey's clarification this morning that the 22 or so individual care homes which will be asked to provide spotlight evidence will comprise care homes with different characteristics, including size, public or private ownership, and geography, and will not therefore be entirely at random.

We set out at paragraph 14 of our written submissions the characteristics that we say are important for the spotlight evidence to reflect, and we hope the Inquiry will take account of what we have set out there, because evidence from the spotlight settings will only be valuable if the chosen settings represent enough of a cross-section of the adult social care

sector to give the Inquiry a proper understanding of experiences on the ground.

On the point that was raised by Ms Carey about the relevance of insurers to Module 6, we maintain that questions about the impact that insurance terms had on the decisions that care providers made, and how it affected their ability to provide high-quality and person-centred care, is at the very least something that ought to be explored with witnesses, including the spotlight setting witnesses.

My Lady, the third and final theme I want to address today is the visiting restrictions.

While the terminology of visiting restrictions is frequently used, I want to be clear that this entails the much broader and crucial question of access to care settings, including access for those who provided essential care.

It will not surprise you, my Lady, having heard our submissions in Module 3, that this is an issue of primary importance to this Core Participant group.

Restrictions on visits into and out of residential care settings persisted far longer and were significantly more onerous than the restrictions on the general population. There were, for example, blanket 14-day isolation rules imposed when people first entered

or re-entered care homes, which effectively prevented trips out of care homes even long after the general population were not subject to lockdown restrictions. And these had a particularly harmful effect on access to health care, because they required two weeks' isolation for anyone who attended a straightforward doctor or dentist appointment outside their home.

The cessation of face-to-face contact and visits into care homes also had a stark impact on access to health care, as specialist health care workers no longer attended many settings and essential caregivers were not able to continue their role.

And of course, it affecting wellbeing more generally, as visits and activities crucial to the good care of people with, for example, dementia and learning disabilities, were withdrawn.

Worryingly, my Lady, these remain ongoing issues as the precedent set by the pandemic restrictions has, in the experience of these Core Participants, resulted in a much greater readiness on the part of care settings to suspend access in response to any infection in the setting.

The Inquiry's analysis of the impact and harm of this approach during the pandemic will, we hope, play a significant role in ensuring that now and in the

future when these decisions are taken, the people that the system exists to support are properly considered and respected, according to the legal duties owed to them, and with a consistent recognition of their value and importance.

My Lady, unless there's anything on which I can assist further, those are our submissions.

LADY HALLETT: Very grateful. Thank you very much indeed, Ms Jones.

I think next is Ms Weston.

Submissions on behalf of Frontline Migrant Health Workers Group: United Voices of the Word, Independent Workers of Great Britain and Kanlungan Filipino Consortium by MS WESTON KC

MS WESTON: My Lady.

I appear, with Mr Clarke of counsel, and Mr Latimer of the Public Interest Law Centre, representing the Frontline Migrant Health Workers Group.

This is a group made up of two trade unions and a charity, which together represent the interests of care workers across the sector, including nurses, non-clinical staff, and both domiciliary and residential care workers, a high proportion of which are migrant workers.

For convenience, I'll refer to the Frontline Migrant

Health Workers Group as the Frontline Group.

Our submissions focus on the experience of care workers and how working conditions of that sector affected both systemic preparedness but also the effectiveness of measures taken aimed at combatting the pandemic generally and protecting vulnerable adult service users in particular.

Having listened carefully to the helpful indications of the Inquiry team this morning, and read and heard the submissions of the other Core Participants, we endorse but do not repeat the submissions of the other Core Participants and highlight two particular aspects of our written submissions.

Building on themes developed in the opening hearing of Module 6, in particular the fragmented nature of the Adult Care Sector, the Frontline Group stresses the importance of ensuring that the Inquiry captures the key features of a range of settings in which care is delivered, including, importantly, the impact of work practices endemic in harder to reach parts of the sector on the safety of an intensely vulnerable population of adults in need of care because they were unable to care for themselves. I know that the court has heard from the Core Participants in detail, and all those submissions we endorse about the vulnerability of that

sector.

So, beginning with the provisional list of issues, our suggestions are set out at paragraphs 7 to 11 of our written submissions for reference. Firstly, as regards the relevant period for the Inquiry's analysis, we agree with the Bereaved Families for Justice Groups who argue in their submissions that the Inquiry's focus in Module 6 should begin by establishing a clear understanding of what the starting position was. That is, the condition of the Adult Care Sector as at 1 January 2020, as the Bereaved Families for Justice put it in their submissions: in order to understand why the care sector was impacted as it was and why it had to respond as it did.

In other words, the Inquiry will be familiar with the term "set up to fail", as issued in the social care context. So we say that a proportionate focus on understanding those pre-existing features of the Adult Care Sector, which bear on the success or failure of the pandemic measures themselves that the Inquiry will go on to examine, is essential.

Part of that focus of conditions immediately prior to the pandemic, we say, should include a proper understanding of the workforce in the sector and the impact of jobs in security, immigration sanctions and

the lack of employment protections which we outlined in more detail in our Rule 9 statement, and refer also to at paragraph 7 to 11 of the written submissions for this hearing.

We say that a sufficient focus on the starting position will inform the Inquiry's understanding of the impact the pre-pandemic position had on later events. This is because the Frontline Group submits that the sector was already vulnerable, owing to, for example, fragmentation, profiteering incentives and lack of effective oversight. So there is a clear connection to be made between the lack of employment safeguards in the sector, and the spread of the virus because significant part of the workforce had no right to sick pay or sick leave and were subject to a range of pressures to continue working while they were sick, and to travel from home to home to provide care.

Secondly, the Frontline Group also agrees with the submissions made by John's Campaign, the Patients Association and Care Rights UK, that the list of issues needs to have a closer focus on care at home, and we've heard a great deal of submissions about the importance of examining the harder-to-reach aspects of domiciliary care. We take on board the indications given by Ms Carey for the Inquiry team today but we do make

further written submissions, and we suggest that if these approaches are adopted and there is sufficient focus on how the structure of the sector, including the care provided in people's homes, affected decision making, then the Inquiry's conclusions on the outcomes and the resilience will be better informed.

The Frontline Group's submission that the evidence before the Inquiry should capture the position in domiciliary care also aligns with the DPO, who stressed in writing and also in their submissions the Inquiry heard this morning, that it's important to obtain and consider the available statistics on the number of people within the adult care sector who died, to also scrutinise carefully the reasons why large numbers of recipients of domiciliary care died during the pandemic.

I'm quoting from their submissions.

I'd like to turn, then, if I may, to the second issue I wish to highlight on the behalf of the Frontline Group, which is evidence gathering.

The group notes the submission of the Bereaved Families for Justice Group's drawing attention to the lack of data concerning the extent to which care homes and also domiciliary care is dependent on migrant workers.

The Frontline Group observes that there seems to be

a degree of consensus between the Core Participants that the Rule 9 requests do not so far appear to encompass evidence from the experiences of the migrant workers themselves.

It's right that the Inquiry heard concerning evidence in Module 3 about the lack of data relating to the sector's reliance on migrant workers, and the consequential difficulties in reflecting their experience during the pandemic.

We agree with the Bereaved Families for Justice groups that the Inquiry can and should ensure, so far as it can, that the experiences of frontline migrant workers themselves are captured.

The Frontline Group's Rule 9 witness statement makes reference to its collective knowledge of the impact of insecurity and vulnerability to exploitation on the extent to which workers in the sector were free to adopt safe practices during the pandemic.

The Frontline Group submits that it should be possible, proportionately, to ensure that the frontline experience of migrant care workers is captured both by approaching advocacy groups already working to support migrant domestic workers, and by hearing from individual workers representative of the migrant care worker experience, particularly in those otherwise hard to

reach but significant parts of the sector, such as independent domiciliary care arrangements, whether privately funded care or publicly funded through direct payments or personal health budgets. The Frontline Group stands ready to provide practical assistance to the Inquiry in obtaining this essential primary evidence.

Regarding the Inquiry's proposed approach to spotlight evidence from a selection of care homes, the Frontline Group agrees with the other Core Participants that Module 3 showed clearly the shortcomings of such an approach, which tend to privilege the institutional or managerial employer perspective. The group agrees with the other Core Participants that, for Module 6, where the Inquiry is examining the resilience of the adult care sector to the pandemic, in the face of some horrifying death statistics which were shared at the first hearing of this module, it's essential that the Inquiry hears from frontline care workers who are able to give firsthand evidence of the extent to which, for example, immigration-related sanctions, lack of employment protections, restricted their ability to provide care safely and, importantly, to follow government guidance.

The group notes that there are two practical

proposals from Core Participants as to how the Inquiry might modify its proposed approach to evidence gathering to meet this objective.

We agree with the Covid Bereaved Families groups' proposal that evidence shut be gathered not only from providers who operate care homes but from those who provide domiciliary care services, and this aligns with the points we make at paragraphs 14 to 17 of our submissions and the oral submissions I've just made.

We note the helpful indication from Ms Carey today that efforts are being made to obtain primary evidence of recipients of care. As to the suggestion by John's Campaign, we agree that further thoughts should be given by the Inquiry to identifying a range of criteria to ensure that different types of care provision are captured, in order to develop an understanding of whether particular criteria placed the service users more or less at risk.

For the reasons that we set out in our written submission and in our Rule 9 statement, the Frontline Group suggests that there is evidence that the precarious position -- particularly in the less visible parts of the sector -- of the migrant carers, which make up a large proportion of the workforce, had a negative impact on both preparedness and resilience of the adult

care sector.

The Inquiry will need, in our submission, to ensure that it is able to scrutinise this feature of the sector in reaching conclusions about the features of the sector which make it more or less likely to be resilient in the future.

Those are our submissions, my Lady, unless I can assist further.

LADY HALLETT: No, thank you very much indeed, Ms Weston.

And, I think, bringing up the rear is Mr Jacobs.

Submissions on behalf of Trades Union Congress by MR JACOBS

MR JACOBS: Good afternoon, my Lady, these are the submissions of the Trades Union Congress.

We have in writing raised four issues. The first related to evidence of the Health and Safety Executive and that has been addressed this morning, for which we are grateful.

The second was expert evidence on the structure of the Social Care Sector. It is a crucial area for this module, both in understanding what happened in the sector and why, and for the learning of meaningful lessons. In Module 2, some of the key decision makers were keen to explain just how limited the levers were to assist the sector, given how fragmented it is.

We note that, contrary to previous indications, no

expert evidence will be obtained in this module on this topic. It is said primarily, as we understand it, that it will be covered in other evidence. The TUC has reservations about that. Rule 9 requests as to the perspective and experience of a single organisation is unlikely to be as broad as that put to an expert, and one value of an expert is to bring together a breadth of views, academic studies, and so on, in a way that stretches beyond the corporate statement and perspective of a single organisation.

Having said that, we don't know the breadth of the Rule 9s that have been put to these organisations, nor who is the maker of the statements, nor the contents. The King's Fund statements has been disclosed but not that of the Nuffield Trust or the Social Care Institute for Excellence. So we do not yet know whether we will share the Inquiry's perspective that these statements adequately cover the issue; we may do. What we say is that we ask that the statements are disclosed as soon as possible and we reserve the right to make submissions on the points in writing and once we have been able to consider them.

Third, my Lady, the provisional list of issues. It currently includes the understanding of the transmission risk presented by staff and the steps taken to address

the same. The TUC invites confirmation that this will include consideration of, firstly, movement of staff between care homes as a factor in transmission. How to address that issue may be important in terms of learning practical lessons for the next pandemic.

Second, other modules have and will consider financial support for self-isolation but it must be touched on in this module. This module concerns a cohort of workers who often are on low pay, often limited job security -- you've heard some of those features addressed by the Frontline Migrant Workers Group just a few moments ago -- and it is also a cohort that work in contact with perhaps the most vulnerable parts of the population.

Moreover, there are particular issues for this module, given the Infection Control Fund. The Fund was made available by the UK Government to address this issue of needing to self-isolate, but there is real concern as to whether it actually served its purpose.

These matters should be considered in this module, we say, of course supplementing rather than duplicating the work of earlier modules.

Fourth, and finally, impact evidence at the public hearings. Clearly, my Lady, it is an issue which is of concern for a number of Core Participants who have

addressed you on it this morning. In Module 3 on healthcare, the Inquiry heard directly from a number of frontline workers. It occupied a proportionate amount of time but, in the TUC's view, was vital and important evidence.

It was necessary both to acknowledge the sacrifice of those who worked in healthcare but also to illuminate the practical problems in the provision of services during the pandemic. There was real value, the TUC says, in hearing directly from someone who had experienced working in a poorly ventilated ambulance waiting for hours with Covid-19 positive patients, in an intensive care unit with terrible fatality rates, on a maternity ward trying to manage under-disruptive restrictions, and so on. Of course, similarly challenging issues arose in social care.

On several issues in Module 3, the impression left by frontline workers and those in central government or management positions were in stark contrast, for example, on questions of capacity and the availability of PPE.

On occasion, my Lady, we recall you putting the experiences of frontline workers to those witnesses in leadership roles. And that, my Lady, is effective inquiry in action.

Before the break, Ms Mitchell made submissions as to the power and impact, both inside and outside of the Inquiry, of direct impact evidence of powerful human stories, and we endorse what she said wholeheartedly.

It appears that this module has moved away from the Module 3 approach, and been limited to organisations describing impact. That, in the TUC's submission, is wrong, and unless driven by a desire to keep hearings short -- which we say is not a good reason -- it is difficult, respectfully, to understand why this module is having a more restrictive approach.

Mr Stanton and others have urged a similar approach to Module 3 in respect of hearing directly from frontline workers, and, of course, those who were reliant on the care provided, and we invite the same approach.

Ultimately, my Lady, the sacrifice and importance of the frontline experience of those working in social care is no less vital than those who worked in health care, and their evidence is likely to be no less illuminating.

My Lady, those are our submissions. Thank you.

LADY HALLETT: Thank you very much indeed, Mr Jacobs.

Ms Carey, did you want to say anything by way of reply?

MS CAREY: Nothing from me. Thank you very much, my Lady.

LADY HALLETT: Very well, then, I'd like to thank everyone for their submissions, Counsel to the Inquiry, obviously, and all the Core Participants. They were extremely helpful and constructive and made some important points. I will consider them all carefully with the Inquiry team, and then decide whether or not I need to make a determination. But thank you all very much indeed. That concludes the hearing.

MS CAREY: Thank you, my Lady.

(12.46 pm)

(The hearing concluded)

I N D E X