AAMER ANWAR & CO
SOLICITORS & NOTARIES

IN THE UK COVID-19 PUBLIC INQUIRY

MODULE 3

WRITTEN CLOSING SUBMISSIONS FOR THE SCOTTISH COVID BEREAVED

INTRODUCTION

1. The Scottish Covid Bereaved has noted the findings and recommendations in respect of module 1 and 2. In particular, we note that any recommendations made have to be "reasonable and deliverable" and we note that the Inquiry intends to supervise the implementation of these recommendations.

2. Nothing in these submissions is criticism of the work done by the nurses, doctors and all other staff who work in hospitals who each played a vital part in saving lives during the pandemic, often at great personal cost, risk and sacrifice. No one should have been called upon to work in the conditions to which they were subject, as spoken to by Dr. Kevin Fong and others including witness W1. We acknowledge and endorse the submissions made by the Trades Union Congress and the Frontline Migrant Health Workers Group in that regard.

3. From the outset the Scottish Covid Bereaved accept that the Chair does not have the power to implement one of the biggest necessary changes, that is to create resources for a beleaguered National Health Service caused by over a decade of austerity and the effect of Brexit. Nevertheless, we believe that there are several issues which can be addressed that if implemented by those with the power to do so, will provide additional protection for us when Disease X arrives.

4. Firstly, we highlight four important issues for the Scottish Covid Bereaved where we believe recommendations can be made that are able to be implemented:

HOSPITAL ACQUIRED INFECTION

5. In 1860 – some 164 years ago and long before arguments about aerosols and droplets dominated the issue - a book was published which stated in its introduction:

" VENTILATION"

6. "The very first canon of nursing, the first and the last thing upon which a nurse's attention must be fixed, the first essential to a patient, without which all the rest you can do for him is as nothing, with which I had almost said you may leave all the rest alone, is this: to keep the air he breathes as pure as the external air, without chilling him. Yet why is so little attended to? Even where it is thought of at all, the most extraordinary misconceptions reign about it."

7. This book, Notes on Nursing, was written by the woman that some of the emergency covid wards were named after, Florence Nightingale.

8. The SCB were witness to the frontline failures which led to such significant hospital acquired infection: the lack of adequate or sufficient PPE; the failure to control movement of patients round the hospital; the failure to control people outwith the hospital mingling and returning there. They have attended hospitals in their own PPE, seen PPE being used inappropriately by health care workers due to scarcity. They have come to learn through this module of the woeful failure of the IPC to act with speed when it was clear that that aerosol was a significant method of transmission. They heard the IPC seemingly did not consider ventilation a matter for them. They have seen the failure of ARHAI to follow its own procedure, to have a clear line of management or supervision. They have come to learn from the evidence of Laura Imrie, clinical lead of ARHAI and member of Covid 19 Review Group that the two main considerations in not employing the precautionary principle were the lack of stock and insufficient fit testing. Equally as extraordinary, that our politicians in Scotland, Jean Freeman and Humza Yousef were unaware that advice on PPE was being tendered to them on this basis. Each would have wanted to know. Whilst Mr. Hancock suggested that it was important that "real world" solutions be found, and as such the availability of stock was of course a factor to be taken into consideration, the charade of suggesting that the NHS as a whole never ran out of appropriate PPE must be

measured by circularity that the advice being tendered on what was appropriate was being influenced by the stock held.

9. The SCB adopts the submissions of the BMA in relation to IPC and the decisions taken in respect of FFP3, and CATA in relation to its submissions on ARHAI. In summary; the bodies whose duty it was to provide time critical EXPERT guidance to protect healthcare workers and society at large failed in that responsibility.

DNACPR

10. It was and remains of enormous concern to the Scottish Covid Bereaved at the time that DNACPRs were most likely to be used, significant flaws in the use of the orders were exposed. Despite best efforts of Counsel to the Inquiry and also questions from the Chair, it is still not understood by the Scottish Covid Bereaved why, if it is a fundamental tenet of the DNACPR process that the informed views of the individual and or family are required, before consent was granted in relation to DNACPRs, this was not happening. Everyone who gave evidence confirmed the centrality of an individual person-centred approach and seemed also at a loss as to why this had gone wrong. Sadly, the SCB have several examples of DNACPR notices being placed on record inappropriately or without the knowledge of families whose concern now is that consent to such a course was never properly obtained. Many did not know of these notices until records were obtained after their loved one's death. Nothing heard in evidence has explained why these issues arose or comforted relatives that the DNACPRS orders were being properly considered and applied.

VISITING

11. In relation to visiting and contact with loved ones, the SCB felt the direct impact of the lack of proper rules and guidance to provide a proper system of visiting and communication with loved ones who ultimately died from covid. The Covid guidance on visiting which was brought in for Scotland seems not to be either known about or if it was, implemented. There seemed no systems or procedures to be relied on, and the ad hoc nature of the decision making on who could have contact with their loved ones, in what way and for how long seemed entirely arbitrary. As highlighted in evidence, this has left enduring trauma with those who lost loved ones that were not able to see them or be with them in their final hours. Those who were able to see their loved ones were sometimes confronted with the choice between attending at their side

of their loved ones in their last moments or attending their funeral. Choices no one should have to make.

12. A running theme in respect of visiting was that of consistency – it is important to the SCB that people know they are being treated equally; one of the most difficult things for those who lost loved ones was to find the different levels of care and consideration that were given to people. This has been no more painful in some finding out that whilst they were not allowed to see loved ones at their last moments, others were. Some were allowed to visit, others were not. A consistent and compassionate policy is required for all. A pandemic must not be allowed to remove our humanity.

THE FAILURE OF RIGHTS BASED APPROACH

13. The Equalities Act provides a Public Sector Equality Duty on the Scottish Government to assess the impact of applying a proposed new or revised policy or practice to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; especially pertinent for a pandemic are the protected characteristics of age disability pregnancy and maternity and race. The fact is that when it was most crucially important to have these issues highlighted in the decision-making process about healthcare decisions in the pandemic, we were told that there simply was not sufficient time to carry out that assessment. The Scottish Covid Bereaved did not need reminded that these decisions were being carried out in a pandemic. As we saw with the UK government in module 2, in times of crisis those most in need, most vulnerable, were not given their proper place when decisions were being taken. The Scottish Covid Bereaved do not accept that when decisions are being taken no equality impact assessments could have been carried out; even where time sensitive matters arose decisions simply ought not to have been taken without reflection and assessment as to how this would affect older and disabled people, the most vulnerable in society. If the cumbersome method of Equality Impact Assessment did not work in a pandemic, an alternative method ought to have been implemented.

14. A failure to ensure the impact of any policy or procedure before implementation, which might affect the most vulnerable were not considered. Decision making without reference to this is unacceptable, and responsibility to flag up problems after the fact is not the responsibility of people advocating on behalf of the vulnerable.

15. In light of the foregoing, the Chair is invited to make the following findings:

16. The NHS was not sufficiently equipped to deal with the pandemic in terms of sufficient personnel or medical capacity

[40/24/21-23] In the words of a consultant from a BMA survey,

"What I needed the most during the pandemic were the colleague I was already missing"

[7/40/1-13] Professor Simon Ball -

"You will have heard, I think, around or you will hear around ICU capacity across the country and it's not simply a -- and how that compares to European comparators, for example, but also there is significant within-nation variation in ICU capacity which is probably important to consider.

I think, broadly speaking, the importance of the build environment in our ability to respond. We've talked about the Queen Elizabeth Hospital. The learning in many ways is the compare and contrast to a modern-built hospital to older infrastructure that we saw across the trust"

[27/59/13 – 27/60/5] Nick Phinn –

"this is implying that there were underlying resilience issues. We tend to operate healthcare services at 85-90% capacity which actually leaves little room for expansion to deal with critical incidents … the one thing that hampered the actual provision [ICU facilities] was actually having the staff necessary to be able to make it function. It's one thing to have a bed but if you don't have the staff able to operate it and look after the patient that's a problem."

[34/133/18-22] Humza Yousef –

"So it was well understood within government that the staffing ratios were not where they needed to be and we were hearing quite publicly as well as privately the concerns being flagged by staff groups, professional bodies and trade unions."

17. That the NHS estate was old and building ventilation has not been given sufficient consideration.

[29/143/3 – 29/144/22] - Amanda Pritchard

"*Ventilation:*

Yes, you're right to point to the challenge with the existing estate rather than the obvious opportunity with new estate. A the moment we have estates, maintenance back log of I think approaching 14 billion so that works to improve ventilation by necessity have to line up with a number of other competing demands on the capital budget. Where there are remedial works to existing trusts I was talking to a college who runs a trust that had had to do quite a lot of work on their maternity unit that is an obvious opportunity to then take into consideration those guidance, those updated HEM guidance and instructions in fact about what the estate needs to look like. So where those opportunities arise it is being considered as part of that work. But what we do not have is an ability at the moment to do a comprehensive review of all of the existing estate with a view to bringing the existing estate up to that standard. However clearly the guidance does talk about those opportunities to use devices like HEPA filters, UV devices. Where the estate is not good enough to be able to meet the ventilation requirements so that would be clearly part of a future pandemic plan.

Estate backlog:

They are two slightly different things in the sense that the estate backlog points to a whole number of things that aren't simply about ventilator, single rooms etc but your fundamental point is right the estate ageing and every year that we are not renewing it it is getting older and old estate is not just efficient it's less adapt well less able to be brought up to the standards that we would now recognise as the standard you would be building into new build"

[34/120/20 – 34/121/3] Humza Yousef -

"some of our hospital estate was older, and I think you have taken evidence from clinicians at the GRI (Glasgow Royal Infirmary), for example, and that was a very well publicised challenge at the time, but most of these challenges around the hospital estate, its infrastructure, the challenges around ventilation, for example, or bed spacing because of the limitations on space, these were issues that were largely aired, again, at the beginning of the pandemic."

18. The NHS was not able to cope in a pandemic to ensure that it provided appropriate and necessary health care for all people who needed its services. Despite efforts to

tone down the "stay at home" message, people who needed medical services still stayed away. Although there were temporary beds set up like the Louisa Jordan, it seems that no consideration was given to who was going to be able to staff them to give care to the patients in these beds. People stayed away from hospital when they should have attended to get important health care, and as a result deaths occurred that might have been avoided if there had been sufficient staff in the NHS to provide resilience in time of need.

[34/88/5-13] – Jeane Freeman

" Q. Dr Claire Mitchell KC - But whilst the Louise is a Jordan provided for extra bed capacity how was it intended to increase the staffing capacity of the Louise Jordan?

A. So a lot of the staffing capacity came from other parts of the health service where we had paused activity and in the senior levels of staffing at Louise Jordan they were from memory certainly the chief executive and the medical director were recently retired in their 50s"

[11/20/4-13 – 11/12/6] - Gregor Smith - 'indirect health harms'

"One of the things that I certainly tried to do in my role as CMO was to make sure that messaging to the public that the NHS remained open for people who needed it was as loud and evident as possible, and I spoke about it on several occasions during the daily lunchtime briefings that I gave with ministers.

I was particularly concerned that as we began to receive data that we saw a real fall off in the early referrals for cancer or for possibility of cancer, that people were not presenting with chest pain and heart attacks to hospital. That illness hadn't gone away, it hadn't disappeared, but people were perhaps absorbing that.

And I think there was a very delicate balance to be given in the messaging to the public, which really had to kind of deal with some of perhaps both people's altruistic sense of protecting the NHS, which was evident, but also some of the fears that they had about presenting to healthcare at that point in time as well. And that was an incredibly difficult thing to do. But messaging was really important, that people with red flags of one sort or another, whether that be chest pain, whether that be suspicious symptoms of cancer that people were seeking help for that. And through social media, through the lunchtime briefings, through any communication portals that I could use I wanted to emphasise that people should -- it was important should still present with that."

[27/58/23 – 27/59/2] Nick Phin -

"it is important that in planning for healthcare system resilience that decision makers have an explicit and shared understanding of what constitutes an essential service, that this includes ongoing surveillance of inequalities in wider health outcomes and determinants of outcomes including accessibility & quality of healthcare provision."

[34/136/13-34/137/6] Humza Yousaf -

"The Royal College of Emergency Medicine has some reports on this issue in terms of people waiting longer than they should for emergency care, what the resultant impacts are of that and very serious impacts of that could be, and of course, we also knew from meeting with specialists in orthopaedics, for example, the detrimental impact of not resuming fully on elective care was having on those that they cared for, the deconditioning, for example, that was taking place. So there's no doubt at all in my mind, and certainly not in the government's, that the increased challenge in capacity and occupancy within our hospitals was undoubtedly having a detrimental impact on members of UK Covid-19 Inquiry 19 November 2024 the public, and it's why, as I think I referenced earlier on during my contribution, that the biggest chunk of portion of my time, if any issue dominated my time as Cabinet Secretary for Health and Social Care, would have been trying to alleviate the pressure that our acute sites were under."

19. The NHS had a poor data infrastructure, meaning records could not always be accessed.

[25/42/7-12] Rosemary Gallagher –

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

[25/76/1-5] *"Despite the fact that you're in a pandemic which is clearly a chaotic and very busy situation, data is absolutely critical to give you an indication over time on what the situation is, but also to be able to adapt and change practices if needed."*

[27/23/5-12] Nick Phinn –

"Well, as I said initially, the work started in April and throughout April and May there was a lot of toing and froing and discussion about being clear about what data Scottish Government needed in order to understand and help them develop their policy and their understanding of what was happening."

[27/60/7-10] *"… highlighting the need for the prompt reporting of data …. One of the main sources of data that we can use can take several weeks to come through once its been recorded and checked."*

[27/60/16-21] *"ongoing issue around data requirements, having things like ethnicity better collected, better completed and other issues around the link to deprivation would have enabled us to identify problems should they have occurred at an early point in time."*

[27/61/15-19] *"There is no similar body in Scotland. You have to go to I think its 22 boards … 8 national boards and 14 local boards to reach a consensus and agreement before you can get something fully implemented."*

20. The NHS did not have sufficient or satisfactory PPE to protect its workforce, patients or the people visiting them. Testing whether or not it "ran out" is not a helpful metric, rather, we should ask was everyone in the NHS protected by access to appropriate PPE and the answer to that was "no"

[25/25/20-24] Rosemary Gallagher –
"So our members were very aware of seeing other nurses in other countries wearing respiratory protective equipment whilst, here, after SARS-CoV-2 was downgraded, they were offered primarily surgical face masks."

[25/33/3-21 – 25/34/4] *"Access to enough supplies of PPE" 30% of respondents said there was not enough eye/face protection for them for the during of their shift. 28% said they have enough now but are concerned for the supply for their next shift. One in four said there was not enough fluid-resistant surgical face masks for the during of the shift. And, again, a quarter of those were concerned about the next shift. And 14% said they were lacking surgical masks.*

32% said they had enough surgery masks for the duration of the shift but are concerned, again, about the next shift. The least shortage was with aprons and gloves. So over the course of that weekend there's still a fair proportion of the responders concerned about face and eye protection, and FRSMs and that was fairly early on in the pandemic, Easter?

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

21. That recommendations were made on what PPE to use based on what PPE was available rather than what was most suitable. The politicians were unaware that the scientists were placing this restriction on themselves, and that "what was available" in terms of PPE was affecting the decisions taken as to what was best to offer advice on protection. Using this method, we cannot know whether or not the NHS had sufficient PPE to deal with this pandemic, as the recommendations for what to use were, in part, influenced by what was actually available rather than what was best to suggest at any given time.

[26/151/15-24] Laura Imrie -
"I think what we need to, or what I certainly reflect, going back at that time, was we were asking people to go to work and look after infectious patients and, you know, with all the media attention and all the death that surrounded them, if you had said "We think you should bring in an FFP3", and they would take that as the guidance, "but actually we don't have the masks to give you", I think that would have been an unbearable anxiety for somebody going into work and looking after Covid."

[36/111/21 – 26/112/2] Matt Hancock -
'Q. But are you saying to us you were of the view that IPC guidance was drawn up on the basis of what was available not what was actually necessary to be recommended to healthcare workers?

A. In a pandemic, availability of stock has to be taken into account, because if you promise -- imagine if the IPC guidance had retained the initial hazmat style –'

22. The use of respirator hoods would have been appropriate for frontline workers in hospitals and for paramedics. Using this type of PPE removes almost all the problems raised in relation to gender/faith/ ethnicity issues.

[28/27/16-20] Prof Simon Ball -

"hoods which are suitable across for a wide range of individuals. Whereas the masks are more dependent upon (a) fit testing and (b), you know, whether you can actually get

a mask to fit you"

23. The use of DNACPR was inconsistent and at times the patient and the families of the patient were unaware it had been put in place and/or unaware of the implications of it.

[21/71/2-9] Jackie O'Sullivan –

"… you can also see how these were then confused with treatment. So you know … intervention, intubation, CPR in its true sense may be something that people may not want to avoid it doesn't mean they are signing away their rights to any treatment at all and that is in practice what was happening."

24. That there was no proper consideration given in respect of infection control to the issue of visitors to hospitals. The guidance [INQ000478112] established to support compassionate visiting arrangements was either not know about or just not implemented

[32/25/22-32/26/1] Colin McKay -

"This is guidance established by the board to support compassionate visiting arrangements at the end of life".

25. That there was an inconsistent approach taken to visiting in hospital and to communication with patients in ICU, leading to additional and unnecessary stress for family members.

[28/33/9-13 Simon Ball –

"There was a lot of positive feedback, both from family but also from the intensive care nurses who felt that they weren't delivering the level of care that they would usually hope to by not being able to speak to or talk to family."

26. That the IPC and ARHAI failed to do their job at sufficient pace to make it useful and failed to adapt to new information to reassess its understanding of transmission (In this regard the oral submissions of CATA are adopted in whole).

27. There was a critical failure by the IPC AND ARHAI to properly listen to the experts many of whom were on the front line dealing with covid (in this regard the submissions of CATA are adopted).

28. There was a fundamental failure to implement a rights-based approach, meaning that the procedural safeguard to put in place to protect the most vulnerable in society were not implemented, and as a result processes and procedures were put in place by the Scottish Government without any real understanding of whether their responsibilities under the Equalities Act was being discharged.

[22/28/15-18] Julia Jones -

"everybody working in health & social care should as part of their training have an understanding of the Equality Act and Human Rights Act"

[22/29/15-16] "*access to healthcare remains a fundamental equal right in our system …"*

29. The frailty scale was used in a way that it was not meant to be used, namely it was used to assess people for treatment for covid – or rather to exclude people from treatments from covid, including decisions to place them on ventilators.

[21/63/20-21/64/1] Jackie O'Sullivan –

"… Rockwood scale, which is attached to the clinical frailty scale that shows very clearly that if you need extra support with your household affairs, your shopping, your bills, maybe taking medication, then you were unlikely to get a ventilator & unlikely to be treated for covid in hospital."

30. The failure to make public messaging clear that people who had to go to hospital to obtain services should still go was a significant public health communication failure which led to people who needed critical healthcare not receive it, sometimes with fatal consequences.

[21/71/5-7] Jackie O'Sullivan –
"… we had the message to Protect the NHS and I think that led to the clinical frailty scale. This was all about relieving pressure on hospitals …"

31. The RIDDOR system was not properly implemented during covid. The Health and Safety Executive did not carry out the job it was properly meant to do. The lack of reporting means that we do not know the true amount of how many people died as a result of contracting an infection at work and whether or not that happened in circumstances where they were not provided with PPE which was sufficiently robust to provide protection.

[25/84/4-6] Rosemary Gallagher –
"the conditions as I recall that were required for RIDDOR reporting were felt to be very limiting in health and care settings"

RECOMMENDATIONS

32. It is known by every politician in the UK that staff and infrastructure in the NHS needs investment. Without this virtually every recommendation is limited by this factor. How practically recommendations can be made to improve this will be difficult but should not stop us trying. The fact is that the most important resource, those who work for the NHS were overwhelmed, and are still suffering the psychological consequences.
33. A National Health Service in this condition cannot even provide adequate healthcare services to its population in non-pandemic times.

HOSPITAL RECOMMENDATIONS

34. There are practical recommendations that might be made to change the NHS, and the SCB hope that consideration is given to the creation of a new body to implement such changes. Further the SCB consider there should be an institution of a formal goverment body in relation to overseeing healthcare. Such a body should be tasked with healthcare issues which are not directly related to the implementation of medical service but nevertheless is essential to a functioning healthcare service. If the recommendation for a new body is not favoured, then each of these following proposals also "stand alone" as proposed recommendations to be implemented by the bodies within the NHS appropriate for that task.

    (a) To create a visiting charter to allow a consistent and fair approach for all.
    (b) To develop moral and ethical principles for a just and fair allocation process for healthcare where demand exceeds supply.
    (c) To "bridge the gap" – to ensure better training is in place for staff to provide greater flexibility – specifically training in ICU shifts – so that people are not learning on the job during a pandemic
    (d) To consider a new hospital role is created, that of a family liaison officer. Such a role would allow for critical communication between patients, staff and family including in relation to DNACPR notices.
    (e) To promote the public health messages necessary for a good death, ie to encourage families to discuss things such as DNACPR notices; to address the role of what was described as "aggressive healthcare" towards the end of life; to facilitate and promote discussions with people and their loved ones about planning for their end of life and what they want. This chimes with the recommendation proposed by Professor Wylie that communications about end of life are normalised between patients, clinicians and their families.
    (f) To consider vital parts of care include the way people are treated and want to be treated. To advise on the use of "respect" forms – as advocated for by Dr. Suntharalingam- a standardised across the nation constituently in order that, as described by Maggie Waterton on behalf of the SCB, that it can be treated with "care compassion and person centred approach."
    (g) To make DNACPR discussions part of the RESPECT form – to allow for discussion about end of life care at the same time as the RESPECT form is being completed.

(h) Data – A recurrent theme in this inquiry is the failure of the NHS to harness technology which could have saved lives; data needs to be gathered intelligently with reference to all the markers age, race etc, centrally collated and transmitted across the four nations. It is submitted that a role of Health Officer be created for each of the 4 nations, mirroring the role of the CMO, to oversee this process. A Health Officer role would not only include the oversee of DATA but liaise with Family Liaison Officers and supervise use of DNACPR and RESPECT forms.

(i) Addressing racism and misogyny in the workplace for NHS workers

(j) Implementing the suggestions of the BMA CP and the Migrant Workers CP in relation to those who work for the NHS, including to provide all workers in the hospital setting, regardless of who employs them, the same workplace protections.

(k) To instruct a study on powered respirator hoods to see if this would be appropriate for all frontline workers, including paramedics. These hoods do not suffer from the difficulties of PPE such as having problems with fitting to age, race, gender and reduce risk of a frontline member of staff contracting covid from a patient or spreading it to others if they have it.

(l) To promote the primacy of the "precautionary principle" in infection prevention control within hospital settings.

INFECTION CONTROL RECOMMENDATIONS

(a) We recommend a full re-shaping of IPC and ARHAI as public bodies. These bodies failed to act at pace, particularly in relation to transmission methods, even when frontline doctors were making it clear that the guidance was not fit for purpose. Consideration needs to be given to the persons who sit on these bodies, including making sure that frontline medical staff are included, as well as a broad range of professionals. Further, a system should be put in place to ensure ARHAI and IPC are transparent as to its make-up, its rules, procedures and guidance. Further, when advice is tendered, it needs to be made clear what the parameters are on such guidance to those whom it is given – this is to reflect the issue which has come to light that the politicians did not realise that the guidance that they were being told about in relation to what PPE to use was being

influenced by what was actually held in stock. This body ought to be made accountable to direct ministerial control.

REGULATORY RECOMMENDATION

(a) A recommendation to review the work of the HSE in Scotland and rest of UK and the use of RIDDOR to see if it is effective. The pandemic has shown that as a public body HSE is not fit for purpose. The inexplicable decision to set a threshold for reporting that was more difficult to meet than it would have been in non-pandemic times meant that a proper understanding of problems arising and accountability for that has been lost. A review of how the HSE worked during the pandemic would identify necessary steps to be taken to improve the system of reporting and the HSE as a whole.

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