IN THE UK COVID-19 PUBLIC INQUIRY
BEFORE BARONESS HEATHER HALLETT
IN THE MATTER OF:
THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

On behalf of Covid-19 Bereaved Families for Justice UK and NI Covid-19 Bereaved Families for Justice

MODULE THREE JOINT CLOSING SUBMISSIONS

CONTENTS

INTRODUCTION

1. The UK was bottom of the league on all key metrics per head of population: numbers of doctors and nurses, number of beds, number of ICUs and number of ventilators [M1:6/151/2-13]. There was woefully inadequate planning. Those are the two key foundations for Module 3 existing as at 1 January 2020, taken from the evidence of Module 1.

2. The heroic efforts of many healthcare workers, from cleaners to consultants, porters to frontline nurses, must not be allowed to obscure the fact that the UK and its constituent four healthcare systems faced the pandemic with no resilience and no plan.

3. The reactive nature of the response was no substitute for proper resourcing and preparedness. Weekly clapping did not produce a single additional doctor. The pretence by politicians, civil servants and key decision makers that UK health systems were not overwhelmed has been comprehensively debunked by evidence: from experts, frontline doctors, migrant workers, and the bereaved themselves. In statistical terms it is measured in the number of deaths.

4. CBFFJ UK and NICBFFJ represent a large number of bereaved families from all corners of the four nations and jurisdictions. Within our group there are doctors, nurses, all manner of healthcare staff, professors, transport and other key workers, the clinically vulnerable, older people, those who were children at the time they lost loved ones, people from many different ethnic minority communities, people with disabilities, and people with comorbidities. They have been able to articulate the effects of the lack of resilience and planning within our healthcare systems, and express the pain of what occurred as a result.

5. Within our group there are also a wide range of experiences of the healthcare system. Some of our members' loved ones experienced care from healthcare workers who battled against a crumbling system to ensure that their patients were treated with the care and respect they deserved. Others were not so fortunate. In their experience, the systemic lack of care and compassion was also evident in the healthcare workers whose duty it was to care for their loved ones.

6. One experience has been universal: a lack of accountability and buck passing by decision makers. The evidence heard in Module 3 shows that this started at the top.

SECTION ONE: CAPACITY OF THE HEALTHCARE SYSTEM

7. The Inquiry's Module 1 report recognised that 2020 found the UK ill prepared for a catastrophic emergency and lacking in resilience. It also found that health and social care services were running close to, if not beyond, capacity in normal times [2]. These are not separate issues: as the Inquiry rightly recognised, preparedness must begin with the building blocks of capabilities [84¶4.2.9]. A healthcare system which is under resourced and stretched close to breaking point during times of calm will inevitably be devoted to struggles of meeting immediate demand. In Module 1, Dame Sally Davies told the Inquiry that the NHS *"has been known for more than a decade to 'run hot', i.e. at full capacity, every winter"* and it was clear from the evidence heard by the Inquiry in Module 1 that as a result, risk management within DHSC was focused on the immediate ability of the healthcare system to meet winter demand.

8. The evidence in Module 3 has painted in stark relief the consequences of this overstretched healthcare system, in terms of both technological and physical infrastructure and human resources. These underlying weaknesses stymied efforts to meet the challenges posed by the pandemic across every area, from the physical constraints of hospitals unable to ensure adequate ventilation, to IT infrastructure poorly equipped to deliver the shielding programme, to a lack of nurses available to properly deliver ICU care.

9. This lack of capacity was evident within every corner of our healthcare system. As Chief Medical Officer Professor Sir Christopher Whitty noted in his evidence: *"the UK has a very low ICU capacity compared to most of our peer nations in high-income countries. Now, that's a choice. That's a political choice. It's system configuration choice, but it is a choice. But, therefore, you have less reserve when a major emergency happens, even if it's short of something of the scale of Covid*." [12/68/10-17]. Expert evidence supported this analysis. As the Inquiry's expert in intensive care, Dr Suntharalingam, explained *"to compare just among OECD figures, we entered into the pandemic with about half the number of the median figure, so we were clearly way behind"* [19/85/11-23].

10. Amanda Pritchard of NHS England confirmed in her M3 evidence that, entering into the pandemic, the NHS had "*historically low bed numbers*" [29/55/18-21]. As she explained: *"The NHS was running at a very high level of occupancy, so there were real pressures pre-pandemic and I think certainly the challenge of not having that headroom, which is described in this section of my statement, meant that there were certain consequences to how we had to respond in a pandemic that did make it particularly challenging"* [29/56/4-10]. The Inquiry's expert, Professor Edwards, highlighted that from the perspective of primary care, the UK does not compare well with other countries, with figures showing *"the*

comparative lack of GPs within the UK and increasing workload this group faces as time progresses" [INQ000474283/9§29].

11. This problem was also highlighted by experts commenting on the ability to continue and address the backlog in non-Covid related care. Professor Metcalfe told the Inquiry that from the perspective of restarting hip replacements, the UK had performed *"very poorly"* and was *"by far the worst performing country"* amongst comparable EU countries. He explained the reason for this was that before the pandemic the UK was already struggling to meet demand [24/91/18-93/12].

12. A stark example of the impact of the lack of capacity within the healthcare system as a whole is the experience Beverley Cook who lost her husband, Trevor Charles Cook. He had been diagnosed with advanced prostate cancer in 2019. In February 2020 their oncologist told her husband *"don't get Covid as you will not be a priority and you will not get a ventilator, the priority is under 34s who have no health conditions".* During lockdown the services which included Oncology, GP, Cancer Home Care and Macmillan Nurses were almost totally unavailable. Beverley spent hour after hour, day after day, chasing down prescriptions, drugs and for someone to come out to her husband. In the meanwhile, he suffered with extreme pain due to advanced cancer which at that stage had reached his bones.

13. The physical reflection of a struggling NHS was the old and crumbling NHS estate which contributed to the high level of nosocomial infections. In Scotland, the weakness of the NHS estate led directly to difficulties in tacking the pandemic, such as the Glasgow Royal Infirmary having inadequate ventilation, as described by Humza Yousaf [INQ000480774/42§182]. As identified by Professor Powis (NHS England) *"the nature of the hospital estate is really important. So many of our hospitals are older and they have more open wards and few single rooms."* Professor Powis went on to recommend that future hospitals should be predominantly single rooms: a change which would require a large amount of investment [28/125/20-126/6]. As accepted by Sir Frank Atherton (Chief Medical Officer for Wales) *"[a] lot of our hospitals are very old. They're from the 60s and 70s … following IPC guidance is a real challenge for many of our hospitals"* [13/67/14-18].

14. Since the pandemic, things have not improved. As Professor Edwards highlighted in respect of primary care, *"these trends continue from before to during and now after the pandemic, raising serious concerns about the resilience of primary care to respond in the event of a future pandemic"* [INQ000474283/5§10]. Ambulance response times continued

to deteriorate after pandemic waves.[1] The bed crisis across the UK continued to pose a threat to patient safety, and as highlighted by Sir Andrew Goddard of Royal College of Physicians *"the fact is, it's simply not possible to have more staffed beds without increasing the number of doctors, nurses and other clinicians available to care for the patients that need them"* [INQ000327695].

15. As Sir Sajid Javid accepted in his evidence to the Inquiry *"prior to the pandemic… if you just look at the number of doctors, number of nurses, number of ventilators, number of IC units, whatever measure you wish to take of the scale of the NHS, it is per capita a lot less than comparable countries with universal healthcare systems… all [the] things that we've been discussing today because the capacity just wasn't there"* [38/99/1-18]. He invited the Inquiry not to *"duck"* this issue but to recommend a restructuring of the funding model for the NHS.

16. We do not agree. Lack of capacity and its consequences on outcomes from Covid, and the ability of the system to mitigate the pandemic are central to the Inquiry. However, the question of where funding for the NHS should come from and how such funding should be structured is beyond scope and no evidence has been heard to enable the Inquiry to properly draw conclusions in that regard.

17. The Inquiry *has* heard clear evidence that the lack of resilience and underlying capacity in terms of staff and resources had an overwhelming impact on the UK's ability to respond to the pandemic. It is equally clear that without significant investment to improve this level of resilience and capacity within the healthcare system, we will not be prepared for the next pandemic. The Inquiry should not shy away from making the findings and recommendations which properly flow from this evidence.

18. The role of an inquiry is unlike a judicial review where there are sharp dividing lines between matters of overarching state policy and political discretion and matters falling within the scope of legal inquiry. Inquiries are not constrained by any restriction of scope, other than their Terms of Reference, which they are bound to address. The issue of sufficient funding to enable the healthcare system to achieve the resilience necessary to respond to a pandemic is at the heart of this Inquiry's Terms of Reference. It cannot address *"preparedness, initial capacity and the ability to increase capacity, and resilience"* and make meaningful recommendations for future preparation without addressing this elephant in the room. Put simply, if this Inquiry does not address such a fundamental aspect of its Terms of Reference, it will not have fulfilled its statutory purpose.

[1] Nuffield Trust, June 2024, url: https://www.nuffieldtrust.org.uk/resource/ambulance-response-times

SECTION TWO: AN OVERWHELMED SYSTEM

19. As discussed above, the UK's already stretched healthcare capacity meant that, when the pandemic hit, the health service simply did not have the staff and physical infrastructure to increase, or "*surge*" resources in key areas to provide care to everybody who needed it. The risk of this had been identified a number of years previously; one of the key learning outcomes identified in Exercise Cygnus in 2016 was the lack of capability and capacity to surge resources in a number of key areas, including the NHS, social care and the management of excess deaths [INQ000022792/6].

20. Our ICU capacity in particular was very low compared to peer nations in high-income countries [12/68/10-17]. As a result, when Covid cases increased, the NHS did not have the necessary reserves to keep pace with demand.

21. NHS overwhelm has been a key issue of dispute in M3 and it may be tempting for the Inquiry to avoid coming to an explicit conclusion on the issue, given that there is an element of subjectivity to the term (Hamza Yousaf [34/134/5-16]). However, CBFFJ UK and NI would urge the Inquiry to make clear findings on the issue because, in our submission, there is an urgent need for change - and recognition is the first step. In order to make the changes that this country so badly needs, and to ensure that our health systems are prepared the next time an emergency happens, it is crucial that this Inquiry does not accept the false assurances from the top of government that "we coped". In the words of experts to the Inquiry, Dr Suntharalingam and Professor Summers:

> "*it is vital to avoid misperceptions that ICU as a speciality 'coped' and needs no further investment - this is not the reality*" [INQ000474255/86].

22. Matt Hancock's evidence was that the NHS "*was never overwhelmed*" and that it was "*always available to all according to need*" and "*we did not have to ration care*" [36/25/14-19]. Although Mr Hancock could not point to a formal definition of what "*overwhelmed*" means, he told the Inquiry that there is a "*sense of what "overwhelmed" looks like*" [36/25/23-25]. The Inquiry has now heard from a number of witnesses who have given first-hand evidence of the state of the health service on the frontline of the pandemic, and the Inquiry can judge for itself whether the situation described by these witnesses, as well as its own experts, would meet any reasonable person's "*sense of what overwhelmed looks like*". A number of features of the evidence are particularly relevant:

    i. Evidence that over 40% of calls to 111 went unanswered at peak times,

ii. Evidence from those who were present in hospital wards and units (healthcare staff and patients) that those facilities did not have sufficient staff, equipment or physical bed space to provide care to the patients who needed.
iii. Rationing of treatment and care that actually took place, as shown by the escalation of care survey commissioned by the Inquiry, set out at para. 42 below.
iv. Vast swathes of treatments were cancelled and patients who would ordinarily have received care did not receive it.
v. Shortages of oxygen were so profound that NHS England was forced to reduce target levels of oxygen saturation in its clinical guidance [INQ000438429/59].

23. CBFFJ UK and NICBFFJ submit that the evidence heard in M3 quite clearly describes a health service that was overwhelmed at multiple points during the pandemic.

Insufficient staff, equipment and infrastructure to care for patients

24. In seeking to understand capacity within the health service over the course of the pandemic, the Inquiry has applied a particular focus to the care of critically unwell patients. Overwhelm in critical care services suggests more general overwhelm of the healthcare system, for reasons that were explained by Inquiry experts Dr Suntharalingam and Professor Summers:

> "*Critical care is an inevitable pinch-point in a life-threatening pandemic due to the nature of care it provides, and since skilled staff and equipment are necessarily resource-limited. ICU is the final common pathway for many acute conditions and hospital activities, including both emergency and elective care; therefore, if critical care becomes overwhelmed, almost all healthcare is overwhelmed."* [INQ000474255/82]

25. Professor Kevin Fong was surprised, at an early stage in the pandemic, by the severity of pressure faced by ICUs and the reality that they were running out of staff and basic equipment [12/4-5/12-5]. He described ICUs as "*overflowing with patients*", "*full*" and running out of staff as well as consumable items such as medication, equipment and basic items on resuscitation trolleys [12/3/18-25]. Smaller hospitals were described as *drowning in patients*" [12/24/6-20]. Professor Fong explained that the lack of available staff in ICU meant that hospitals were limited even in the steps that they could take to reduce pressure on facilities; at times there was insufficient intensive care and anaesthetic medical staff to be able to transfer patients out [12/5/6-9]. The overall effect was that:

> "*At many times and in many places the units were overwhelmed… These units were beyond their capacity to cope"* [12/52/13-17]

26. Dr Suntharalingam and Professor Summers were clear in their report that, when considering ICU capacity, there is "*a critical distinction between the availability of physical bed spaces and the delivery of ICU care, which is provided by a multidisciplinary team of specialist staff*" [INQ000474255_0057]. That means that, even where there are physically enough beds in ICU, it does not mean that those units have capacity to treat patients safely. The delivery of safe care is dependent on other factors; most importantly the availability of what the experts described as "*staffed, equipped ICU beds*" [INQ000474255/7].

27. The Inquiry has heard detailed evidence in relation to the stretching of nurse staffing ratios from the recommended level of 1:1 to 1:6 in England [6/17/9-10; INQ000474255/58; INQ000389244/22] and, as Dr Suntharalingam confirmed, sometimes beyond this [15/67/13-18]. Dame Ruth May conceded that this was "*not ideal at all, and I know that – I know there's been consequences because of it"* [6/42/5-7]. Similar decisions were taken in Wales and Northern Ireland [6/103/12-14, 7/45/6-21] . Professor Fong was clear that stretched ratios continued into and throughout the second wave of the pandemic [12/53/14-25].

28. We submit that the need to stretch staffing ratios in this way for the most critically ill patients was a clear sign that those units were exceeding their capacity. Professor Fong described the impact that this decision had both on the staff involved, and on patient care:

> *"Nurses were nursing at a ratio as low as 1:6 actually, at that time; one specialist care nurse to six intubated ventilated patients...they were telling us that they couldn't operate at this level, they -- these diluted ratios, with one specialist ICU nurse covering four or six patients at a time. I remember in another hospital the nurses telling me that all you have time to do is to manage the alarms; you're not managing the patients ... you're putting out fires, rather than caring for the patient"* [12/9-10/4-2].

29. Professor Fong acknowledged that the impact of diluted staffing ratios meant that "*it was not possible to deliver the standard of care that would ordinarily be expected in a non-Covid period"* [12/54-55/12-4]. Dr Saleyha Ahsan described how, on attending the ward in which her father was being treated in December 2020, she witnessed a system that was "*so overwhelmed*" and staff "*were exhausted, running on empty, just overwhelmed by the numbers*" [39/86/20-22]. She and other members of her family had to "advocate hard" for her father to even be transferred to a Covid ward despite symptoms of Covid and a chest x-ray that raised suspicion of it, and Dr Saleyha ultimately took compassionate leave from her ITU job in North Wales in order to provide one on one care to her father herself

[INQ0000474260/4]. She discussed in her evidence how she found it "*truly frightening*" that if her father had not had family members to advocate for him, his care would inevitably have been less because staff were so overrun [39/86-87, 12-19]. She spoke candidly about her concern that overworked nurses would not have time to carry out basic checks such as ensuring her father's CPAP was in place to deliver oxygen [39/89/1-9]. Her father was not admitted to the ICU. As his consultant explained to the family, in normal times he would have been a candidate for intensive care, but the resource pressures meant that he could not be admitted [39/85/18-86/6].

30. This first-hand evidence of the impact of overwhelm on patients aligns with a study carried out by the Intensive Care National Audit and Research Centre ('ICNARC') which investigated outcomes in the cases of 130,689 patients admitted to 210 adult general ICUs in England, Wales and Northern Ireland during the pandemic period [INQ000250242]. That study found:

> "*…significant association between exposure to higher ICU capacity strain and higher acute hospital mortality, both overall and for patients with COVID-19 and non-COVID-19, with increasing levels of ICU capacity strain associated with increasing mortality*" [INQ000480139/8]

31. In one hospital, Professor Fong explained that there were so few staff that nurses could not take a toilet break because there was no one to cover their nursing duties. They had chosen to either use the patient commodes in the side rooms or to wear adult diapers [12/27/2-7]. CBFFJ UK and NI would suggest that a situation in which ICUs are so understaffed that healthcare workers are not able to meet their basic needs in this way is quite clearly indicative of overwhelm, and that pushing healthcare workers to breaking point inevitably puts their safety and patient safety at risk.

32. In one particularly harrowing part of his evidence, Professor Fong described the state of overwhelm facing healthcare workers:

> *"We had nurses talking about patients raining from the sky, where the nurses said that they -- one of the nurses told me that they'd just got tired of putting people in body bags, and at the hospital where they said sometimes they were so overwhelmed that they were lifting -- putting patients in body bags, lifting them from the bed, putting them on the floor, putting another patient in their bed straightaway because there wasn't time"* [12/21-22/24-7].

33. As well as insufficient staff and equipment, Professor Fong told the Inquiry that units were also running out of physical space: "*intensive care areas were already full. So their baseline was already full, and they had split out into their operating theatres*" [12/7-8/25-1]. In one particular hospital, he described:

> "*The intensive care unit was full. Their overflow areas were full. Their non-invasive ventilation unit, their respiratory unit was full. This was a hospital bursting at the seams ... It is genuinely the closest I have ever seen a hospital to a state of collapse in my entire career*" [12/27-28/8-18].

34. Taking these features together, the Inquiry will hardly need reminding of Professor Fong's comment that of all the very serious civilian major incidents he had worked on, including terrorist attacks, nothing that he had seen in those events was as bad as Covid was, "*every single day for every single one of these hospitals throughout the pandemic surges.*" [12/23/3-12]. He described arriving on a unit and how "*It was just -- it was a scene from hell.*" [12/26/17-18].

35. Evidence from other parts of the healthcare system confirms that services were unable to cope with demand at times during the pandemic. Catherine Todd described how there were not enough staff to look after everyone in the maternity unit [3/22/1-12].

36. The Inquiry has focused on ICU capacity. There has been less focus on the dire situation of Covid-19 wards beyond critical care. CBFFJUK member Clare Farnsworth lost her mother Mary as a result of nosocomially acquired Covid-19 on 13.01.21. She was present during her mum's admission and witnessed the full horror of the realities on a Covid-19 ward. There were two nurses responsible for 40 patients on an overnight shift, resulting in patients' treatment and care being neglected.

37. Expert to the Inquiry Professor Helen Snooks described how NHS 111, 999 and ambulance services were overwhelmed at times during the pandemic [INQ000474285/25; 22/139/10-13]. This supports the evidence given to the Inquiry by John Sullivan, who waited around six hours for an ambulance in late March 2020 for his daughter Susie, during which time he called to chase three times, only to be advised by a pharmacist not to wait and to take Susie to hospital himself [2/123-134/23-9].

38. As a result of overwhelm in emergency prehospital services, Professor Snooks found that "*processes of care were affected which detrimentally impacted on the safety and quality of care provided*", and that calls were not answered and/or response vehicles were not available for dispatch [INQ000474285/25]. It is important that the Inquiry considers this

hidden aspect of emergency care overwhelm and considers whether the difficulties experienced by people in accessing emergency care artificially supressed demand for critical care services and led to avoidable deaths.

Rationing of treatment and care

39. The Inquiry has heard clear evidence in M3 that rationing of treatment and care took place during the pandemic. This is a key metric for judging whether the health service was overwhelmed, as was identified by Matt Hancock himself in M2:

> *"Had the NHS been overwhelmed, treatment would have had to be rationed, and choices made between who to treat and who to leave."* [INQ000232194/6]

40. Inquiry experts Dr Suntharalingam and Professor Summers explained the way in which pressures on bed spaces and ICU capacity (as set out above at para. 26) influenced clinical decision-making and prioritisation:

> "*If units are becoming realistically saturated under the conditions at the time, that's what's going to start influencing clinical decision-making, albeit subconsciously, and in practical terms through simple lack of available beds*." [19/46/4-7]

41. This echoed the detailed account given in their expert report, which explained that in the circumstances of the pandemic, "*variations in decision-making and conscious or subconscious application of clinical thresholds are likely to have occurred through the sheer complexity of the circumstances*" [INQ000474255/51]. The report further explained:

> *"Unfortunately, it is likely that in practice, ICU capacity was overwhelmed in some individual locations at certain times and that the criteria for ICU admission changed via local informal processes (conscious or unconscious alterations in decision-making by individual clinicians rather than due to policies or guidelines being issued) when capacity was stretched, meaning those who might usually be admitted to ICU were not..."* [INQ000474255/61]

42. The existence of resource-based prioritisation or ceilings of care is further supported by IFF research commissioned by the Inquiry. A survey of 1,683 healthcare professionals found that 58% reported that "*some patients could not be escalated to the next level of care due to a lack of resources during either wave of the pandemic*" [INQ000499523/3]. This was confirmed by 71% of the A&E doctors surveyed. The primary reasons for the inability to escalate care were a lack of available beds and a lack of staff (overall or at the

right level) [INQ000499523/3]. Matt Hancock was unsurprised by these survey findings; commenting "*I'm not surprised in the least. And of course we knew that these pressures were intense*." [36/47/4-5] and "*[t]his is what was going on in the ICUs of the nation*" [36/47/16-17].

43. Commenting on research by the ICNARC, experts Dr Suntharalingam and Professor Summers note in their report that patients admitted to ICU during the first wave of the pandemic were younger and less severely ill than those admitted pre- and post-peak periods. This evidences that "*efforts were directed at saving patients with the greatest chance of survival (those who were younger and previously fitter but with the most severe illness) during the peak of the first wave*" [INQ000474255/64], even if that was not an express policy. A further finding of ICNARC research was that ward mortality was highest when older patients were least likely to be admitted into ICU, which the experts consider indicates that *"these patients may potentially have benefitted from ICU admission*" [INQ000474255/64].

44. A number of specific examples have been given in evidence of the withholding of care for those who needed it due to pressures on the system. Dr Ahsan described how her sister had a senior clinical position at the hospital where her father was, and that it was "*overwhelmed by Covid*". The ITU consultant responsible for her father candidly explained that he could not be admitted to critical care or HDU because there were no available beds, and indeed that was the picture for much younger patients too [INQ0000474260/4]. This was a capacity and not a clinical decision:

> "*Essentially, we just had a really sort of frank discussion with the consultant and she said, "Look, you know, and I know that this isn't how it would normally be. I have got 40-year-old male patients that I am trying to desperately find an ITU bed for across the region, you know, that's what I'm dealing with." And at that point I knew that this is it for my dad*." [39/85/18-24]

45. John Sullivan has told the Inquiry of the decisions made on 27th March 2020 in relation to his daughter Susie, who was not escalated to ITU due to the fact that she had Down syndrome and a pacemaker [2/131/3-20]. A Serious Incident Investigation into her death confirmed that a decision had been made to impose a "*ward-based ceiling of care*" [INQ000483295/4]. Neither Down syndrome nor a pacemaker was relevant to a decision as to admission to ICU. Susie died on 28th March 2020. Background and context relevant to the incident was identified by the Trust as "*unprecedented numbers of unwell patients in challenging environments*", "*immense pressure on beds, including critical care beds*" and staff were "*reviewing an increased number of patients"* [INQ000483295/5]. Occupancy

in ITU on 27th March 2020 was 27 level 3 patients. ITU baseline capacity was 23 beds (normally staffed for 9 level 3 patients and 14 level 2 patients) [INQ000483295/8].

46. In evidence, Matt Hancock confirmed that he was made aware of cases like Susie's [36/45/15], as well as reports of the misuse of DNR notices, commenting "*they're all part and parcel of the same thing, because it's about availability of care*" [36/43/16-20]. It is staggering to the families that we represent that Mr Hancock could maintain his assertions that the system coped, and that it did not become overwhelmed in the face of this evidence. We address the issue of DNACPRs at Section Six, below.

47. On the evidence, it is submitted that the following conclusions can be drawn:

    i. Not everybody who needed an ICU bed got an ICU bed during the pandemic.
    ii. Critical care was withheld from some patients due to a lack of resources.
    iii. At times of higher Covid cases, such as during the first and second waves, there was a system of informal, resource-led clinical prioritisation or triage.

48. Turning patients away who were in need of care was a clear sign of a system that was overwhelmed and, in our submission, this led to increased fatalities.

Core treatments and services were cancelled/ reduced

49. As Professor Summers explained, efforts to increase intensive care capacity came at the cost of other health services:

> *"Every time we opened an intensive care unit, we stretched what we had further and further and further and drew in more and more resource from elsewhere in the hospital and diluted what we already had"* [15/58/10-13].

> "*The equivalent of about 141 extra intensive care units were required in January 2021 above the capacity that was available in January 2020... we did not create that physical capacity of 141 extra ICUs with any more staff, to reiterate that point again; we did it with exactly the same number of staff as we had in January 2020 in terms of specialist critical care staff. We stretched what we had to make that extra capacity."* [19/58/1-6]

50. A Public Health Scotland Scottish Intensive Care Society Audit Group ('SIGSAG') report based on a survey of Scottish ICUs on 23rd September 2021 gives an example of the scale of redeployment required by ICUs. The survey found that only 39% of ICUs were able to maintain recommended nurse-to-patient staffing ratios with ICU-trained registered nurses

from their own unit. In the remaining 61% of units, recommended staffing ratios (presumably, even at diluted levels) could only be maintained with nursing staff who did not usually work in the ICU [INQ000470091].

51. The data does not reflect the full picture in relation to critical care capacity strain. The pressures on critical care units meant that many critically patients were treated on general wards. In some hospitals half of the patients receiving critical care were outside the ICU, but these patients were not captured in ICNARC data [INQ000474255/61§157]. Professor Summers highlighted the impact of this on quality of care due to factors such as staffing ratios and the experience and qualifications of care providers. As Dr Andrew Goodall (Permanent Secretary to the Welsh Government) accepted, patients who were critically ill but were managed outside of the normal critical care environment were therefore exposed to greater risk [31/102/6-103/9].

52. It is therefore clear that, as a result of the health system's inability to meet demand and the re-allocation of resources to critical care, staff were pulled away from many non-Covid, non-critical care services. Many patients did not receive treatment that they needed, such as operations and other procedures due to concerns in relation to overall capacity within the NHS [36/28/6-8]. Inquiry expert Dr Guy Northover described an increase in very long waits for an admission for inpatient mental health services for young people, including, in one instance, a wait of 111 days for a bed [24/146/12-18]. Matt Stringer from the Disabilities Charity Consortium gave evidence regarding a report from MENCAP which detailed heightened concerns from healthcare staff at the effect of specialist Learning Disability nurses being redeployed during the pandemic, sometimes leaving no specialist services at all. This was linked to data showing disproportionate fatality rates amongst patients with learning disabilities, Down syndrome and autism [20/19/96-102 and INQ000176404/24].

53. The cessation or reduction of core health services is further evidence of a health service in a state of overwhelm.

54. The evidence also points to a reduction or delay on the part of individuals with non-Covid conditions in seeking medical help [36/37/6-11]. As a result, there was a substantial decline in admissions for a range of serious conditions, such as heart disease and suspected heart attack. Inquiry expert Professor Chris Gale found in his report that a number of people requiring medical treatment for suspected heart attack did not attend hospital, and that this led to an excess of cardiovascular deaths during the pandemic period, and an increase of deaths at home and in care homes compared to non-pandemic periods [INQ000494739/80, 90]. It is important, when considering overall capacity and resilience that the Inquiry considers that many more patients should have been in hospital during the

time of the pandemic than were [INQ000494739/127], and that this was (at least in part) due to the fact that significant numbers of patients who needed emergency care were not in hospital.

SECTION THREE: INFECTION PREVENTION AND CONTROL

55. In his evidence to Module 3 the former Health Secretary Matt Hancock asked us to remember that "*hospitals are dangerous places in pandemics*", noting the estimate that "*more people caught Covid in hospitals than in almost any other setting*" [36/69/1-4]. This terrible reality is reflected in the evidence of Dr Shin, Professor Gould and Dr Warne, who concluded that the number of patients who contracted a hospital-acquired Covid infection in the UK was well over 100,000 [8/148/12-16] and Professor Hopkins, who confirmed UKHSA's finding that between March 2020 and April 2021 in England alone, there were 29,950 hospital-acquired infections, of which 9,854 people died [7/195/9-17]. This figure is almost certainly an underestimate, from the experience of the families we represent, who have found that there is often a failure to acknowledge or record nosocomial infections. The Inquiry will have the human cost of each life lost well in mind.

56. In our Opening Statements CBFFJ UK and NICBFFJ invited the Inquiry to consider whether the UK threw caution to the wind by failing to limit healthcare related transmission of Covid-19 through proper IPC measures. In our submission the public hearings have only served to highlight the fundamental flaws in the UK's approach to IPC, grounded in the fatal decision to discount the possibility of airborne transmission in March 2020 and to maintain that position throughout much, if not all, of the relevant period.

Airborne transmission

57. The Inquiry has had the benefit of expert evidence from Professor Beggs, whose opinion in 2020, as now, was that Covid-19 was airborne [3/42/20-23]. This view was consistent with the known modes of transmission of SARS-CoV-1, which Covid-19 so closely resembles, and which was said to be the starting point for analysing Covid-19 in the earliest stages of the pandemic response. Other experts, such as Prof Lidia Morawska, were publicly raising such concerns at an early stage [INQ000474276/53-54]. The Inquiry will recall the paper written by Dr Ritchie, former Chair of the UK IPC Cell and others including Professor Van-Tam, which noted not only that SARS was transmitted by "Droplet/aerosol" but also that FFP3 respirators should be used when caring for patients with SARS [INQ000130561]. It is respectfully submitted that in evidence Dr Ritchie was unable to satisfactorily explain the rationale for disregarding the possibility of aerosol

transmission and the need for FFP3 respirators while using SARS as a starting point for the management of Covid-19 [100-104].

58. There was also early evidence of aerosol transmission of Covid-19 itself as recognised by Professor Sir Gregor Smith, who noted that some of the early observational studies, including one from China, suggested that there could be "at least some contribution from aerosol spread" [11/35/19-24]. An evidence summary prepared for SAGE on 14.04.20 referred throughout to aerosol transmission, noting that the limited evidence to date indicated that virus had been detected up to 4m from the source in air and in corridor air adjoining patient rooms, albeit that it was not known whether this was viable or at sufficient concentration to cause infection [INQ*192047]. Professor Whitty agreed that it was acknowledged "fairly early on" that there was likely to be airborne transmission [12/1383-6].

59. Whatever the strength of the positive evidence for airborne transmission in the early stages of the pandemic, and whatever the prevailing view as to the relative significance of airborne transmission, it is quite clear that there was no basis for excluding such transmission as a significant possibility and formulating IPC guidance according to that erroneous premise. Witnesses including Professor Beggs [3/120/1-21] and Dr Barry Jones [4/8/11-22]; [4/14/19-16/11] robustly and compellingly set out the simple proposition that a precautionary approach was required in the face of uncertainty about the mode of transmission of this new and deadly coronavirus.

60. As the Inquiry heard, the UK did not adopt such a precautionary and open-minded approach to modes of transmission and appropriate safeguards. Instead, the pandemic response in healthcare proceeded on the assumption that the virus was "droplet borne"; that this was the main route [3/118/1-4]. On 28.03.20 the WHO tweeted that Covid 19 was "NOT airborne", a position described with understatement by Professor Whitty as "surprisingly definitive" Yet despite Professor Whitty's evidence that "we all knew that the data were not yet clear enough to make a decision one way or the other" [12/82/17-19] this was the position taken by Professor Powis of NHS England, Yvonne Doyle of PHE and Carrie MacEwen of the Academy of Medical Royal Colleges in a letter to colleagues about PPE that same day [INQ000130506]. It was the position adopted and maintained by the UK IPC Cell, despite witnesses' insistence that they were guided by the science.

61. On behalf of PHE/UKHSA Professor Hopkins told the Inquiry that "we were cautious in the early days because of the lack of evidence" in respect of airborne transmission outside AGPs [7/98/11-12]. In our submission the imposition of what Professor Beggs characterised as "*a very high bar of proof*" [3/121/17] in respect of airborne transmission

in fact amounted to a lack of caution in respect of the health and wellbeing of healthcare workers and their patients. In this regard the Inquiry will recall the evidence of Professor Noakes in Module 2. Professor Noakes said that "although the evidence at the outset was weak, in truth it was weak for all transmission routes" and took the view that "there was just a tendency to assume the other transmission routes, and then require the evidence for airborne transmission" [PHT000036/017-18]. This is perhaps best illustrated by the Government emphasis from the outset on hand washing, which in reality proved to be of minimal effectiveness. Professor Smith's warning about the need to ensure that absence of evidence was not interpreted as evidence of absence was not heeded [11/34/23-24].

62. Dr Jones confirmed that the approach taken to airborne transmission cannot be explained by reference to a divide between physicists and engineers on the one hand and clinicians on the other [4/4/17-20]. The attempts by CATA and its clinician members to make the scientific case for appropriate measures to address the risk of airborne transmission were repeatedly rebuffed by those responsible for formulating IPC guidance. In the absence of any scientific evidence to support their position, Dr Jones considered their claims to be "following the science" to be untrue [4/18/6-22].

63. In their evidence to the Inquiry both Dr Lisa Ritchie and Laura Imrie of the UK IPC Cell reiterated that the UK IPC Cell was guided by the views of scientific experts, including SAGE, UKHSA, PHE and NERVTAG [5/71/13-15; 6/104/24 – 105/4]; [26/116/6-12]. However, it is submitted that this proposition does not withstand scrutiny. It is notable in this regard that despite their leading role in this part of the pandemic response, in our submission neither witness displayed significant understanding of or engagement with (i) the material pointing towards the likelihood of airborne transmission from the very start; or (ii) the developing evidence base in respect of airborne transmission over the course of 2020 and beyond.

64. When asked by the Chair whether the IPC Cell had become wedded to the idea of droplet transmission, Dr Ritchie replied that "if we had been advised by the scientific advisers from SAGE, from NERVTAG, that there was a potential of airborne and that actually we needed to move, then we would have moved to that position" [5/158/17-20]. However, no explanation was proffered as to how she would expect such advice to be provided to the Cell, and no suggestion that the UK IPC Cell specifically sought advice from SAGE or any other scientific advisory body in respect of routes of transmission.

65. The families we represent were dismayed by the evidence given by Dr Ritchie, and were left concerned about the leadership of the IPC cell and its expertise.

66. We note that a paper by EMG and NERVTAG entitled 'SARS-CoV-2 Transmission Routes and Environments' was considered by SAGE on 22 October 2020 and expressly referred to 'longer range respiratory aerosols' as one of the three main routes of transmission. The paper went on to note as follows:

> *"Airborne transmission occurs when small virus-containing respiratory aerosols are carried by the air and subsequently inhaled. These aerosols may be released from respiratory actions (breathing, talking, coughing etc), as well as through aerosol generating procedures in a hospital or dental environment. Airborne transmission is associated with infection beyond 2m in poorly ventilated rooms."*[2]

67. In our submission the evidential picture as set out in this paper goes well beyond the 'potential of airborne' and should have been known to the specialist body responsible for advising on IPC guidance across the UK. We note that according to gov.uk it was published online on 6 November 2020.

68. Professor Beggs also makes clear that there was anecdotal evidence of airborne transmission from well before September 2020 (INQ000474276/53-54). The CMO Technical Report cites the Skagit Choir Superspreader event as an early example from Spring 2020 of outbreaks in Choir groups. (INQ000177534/52 and 79, Footnote 205, referencing a CDC report of the incident published in May 2020). The Skagit Choir event occurred on 10 March 2020, was reported by the LA Times on 29 March 2020 as supporting a conclusion that transmission was through the air, and was reported by the US CDC around the same time (Prof. Heymann Expert Report, INQ000195846__18§79). The CMO Technical Report, Prof Heymann's report, as well as Prof Beggs' expert report, all identify a number of incidents which had occurred in January and February 2020 (not limited to choirs) which supported conclusions of aerosolised transmission, and which were reported in both scientific literature as well as the media (INQ000195846_17-18§§79-80; INQ000474276/53-54). Sufficient material to support a conclusion that there was airborne transmission, both anecdotally and based on the knowledge of scientific experts, was therefore available in Spring 2020.

69. At the beginning of her oral evidence, Professor Hopkins agreed that it was part of PHE's role to translate SAGE's advice into guidance for all settings, including clinical settings [7/64/10-17]. However, it appears that PHE failed to discharge this role effectively as far as the UK IPC Cell was concerned and/or that PHE's specialist role in this regard was not

[2] https://www.gov.uk/government/publications/sars-cov-2-transmission-routes-and-environments-22-october-2020

recognised by the UK IPC Cell. This is illustrated by the approach taken in the Cell meetings on 22 and 23 December 2020 which were addressed in oral evidence before the Inquiry. On 22 December it is recorded that Mr Brown provided advice on behalf of PHE, namely that *"[o]ur understanding of aerosol transmission has changed" and that "[a] precautionary approach to move to FFP3 masks whilst we are awaiting evidence should be advised"* [INQ0000398244]. At a 'huddle' the following day it was recorded that "there may be an increased risk of increased aerosol transmission following evidence re singing, shouting and enclosed spaces" [INQ0000130587]. Yet there is little evidence in the minutes of evaluation of this changing evidential picture and as the Inquiry has heard, the precautionary move to FFP3 use was not pursued.

70. One important responsibility for the Inquiry is to identify what flaws there were in the response, and to identify how these can be avoided in the future. It is therefore significant that qualified experts had identified from the outset that they believed that airborne transmission was not only a possibility but was likely. Those experts were supported by anecdotal evidence (at least) and those experts have ultimately been shown to have been right. The fact that they were not heeded from the outset was in itself a failing. The pandemic response would have been more successful if those experts had been listened to and their expertise had informed the response. The Inquiry's recommendations should reflect that (i) it was an error not to utilise their expertise, and (ii) that to avoid such errors in future, there must be mechanisms to ensure that the reasoned views of properly informed experts are listened to, and that these are not dismissed as "outliers" simply because numerically more (though less-well informed) scientists do not hold the same views. Where a fundamental risk such as airborne transmission exists, and there are important expert voices urging caution, they must be heeded. Reliance on the "mid-point of scientific opinion" is misconceived in this context.

FFP3 respirators

71. The evidence before the Inquiry has considered at some length the most significant practical result of the decision to disregard the possibility of airborne transmission for IPC purposes, namely the downgrading of protective equipment for those providing routine care to confirmed and suspected Covid-19 patients from FFP3 respirators to FRSMs.

72. While there is evidence before the Inquiry, including from Professor Hopkins, that the evidence about the enhanced protective value of FFP3 masks is weak, this has to be considered in light of the serious challenges associated with designing appropriate trials in this area. It is noted that Professor Beggs was able to provide a pithy summary of the findings of the Royal Society expert group that "wearing masks was better than not wearing

masks, and respirators were better than surgical masks. It's as simple as that, really" [3/133/19 – 134/9]. The Inquiry is also referred to the evidence of Dr Warne, including his explanation that there have been "observational studies which show that FFP3 respirators or other types of respirator are associated with lower risk of transmission, particularly to healthcare workers" [8/42/10-15].

73. We submit that the Inquiry will need to examine with care the cogency of the claim that the initial decision not to recommend use of FFP3 respirators was not influenced by resource considerations. Was this decision simply a serious failure to consider the science and adopt a precautionary approach to protect healthcare workers dealing with a dangerous new pathogen, or was there also an underlying driver behind the decision, namely resources?

74. There is evidence before the Inquiry which tends to suggest that resources were taken into account in decision-making in this area. It is noted for example that the minutes of the NERVTAG meeting of 6 March 2020 (at which Dr Ritchie was present) record that Professor Horby asked why there was a proposed change from FFP3 to surgical masks as it was not clear from the underlying documentation. The need for preservation of stocks of FFP3 respirators (in that instance for confirmed cases or where AGPs were taking place) was cited as a reason for the change: "*JD responded to say that it is a phased change in that not all suspected cases will be positive and therefore it is reasonable to save the higher level of care to preserve stocks of FFP3 respirators for the confirmed cases or areas where aerosol generating procedures (AGP) are taking place*." [INQ000229192/3, para 2.3]

75. In one of her statements for the Inquiry Professor Jenny Harries noted that as at 25 March 2020 *"[t]here were […] extremely constrained supplies of respirators, and so they were prioritised for staff performing the highest risk activities*" [INQ000489907/31, §6.33]. In answer to questions from the Chair, Mr Hancock said he had gained the impression that IPC guidance would take into account "*the places where they [FFP3 respirators] were most in need and could save most lives*" [22.11.24 p37/10 – 39/17]. Most notably, when first asked about the application of the precautionary principle in this regard, Ms Imrie pointed to "supplies" as a significant factor, observing that *"[i]f we wrote guidance as a precautionary principle to put everybody into FFP3 then not only would they have had a large amount of the workforce that couldn't comply with the guidance, and therefore couldn't come to work, we would also have had high risk areas where we had identified for intensive care units, high-risk pathways that might have been left without the FFP3s"* [p149]. In our submission, there is the clearest evidential foundation for the inference that decision-making was informed by resource constraints.

[Return to contents] 20

76. We readily acknowledge that these early decisions were taken in the context of unprecedented global demand for, and shortage of, protective equipment including respirators. However, this context makes the imperative of transparent decision-making all the more important in order to retain trust among healthcare workers and patients, and to plan for the future. As Dr Jones explained, healthcare workers would have understood the position had they been told that stocks were short [4/42/10-25]. In his statement Dr Jones notes that the UK's position differed from the EU and USA, both of which required use of the highest protection factor of RPE available, depending on supply factors [INQ*273913/97, §296].

77. It is submitted that the Inquiry will also need to examine carefully the rationale underpinning the UK IPC Cell's refusal to change course in respect of airborne transmission and the use of FFP3 respirators. Dr Ritchie told the Inquiry that what would have been needed for a move to FFP3 use would have been "a conclusive statement that Covid-19 was airborne" [5/116/9-18]. In our submission this was available from an early stage, and certainly by the end of 2020, but there was no change. The Inquiry will no doubt scrutinise the recorded responses to proposals for change in considering the extent to which the Cell was influenced by a desire to save face or avoid confronting criticism or concerns from healthcare workers about the approach they had adopted at the beginning of the pandemic [INQ*398244; INQ*130587; INQ*398184].

78. Finally, when evaluating the IPC guidance in the pandemic, the Inquiry should have regard to the striking lack of clarity about the governance arrangements for such an important element of the pandemic response. This would be a cause for considerable concern in and of itself but in our submission reveals a general reluctance to take responsibility for such obviously flawed decision-making and its consequences. The Inquiry is invited to compare, for example, the evidence of Dr Ritchie and Dame Ruth May about the ability of PHE to veto the IPC guidance against that of Professor Hopkins that the UK IPC Cell alone had 'sign-off' [7/107/6-7]. In summary, no witness has been willing to take ownership of the expertise and the responsibility for these critical decisions.

SECTION FOUR: PRIMARY CARE, NHS 111 AND 999 SERVICES

79. As highlighted by Professor Snooks, *"planning and preparedness was inadequate at national level for 999 or 111 services to meet operational and clinical needs during the Covid-19 pandemic"* [INQ000474285/10§23]. This lack of planning was also evident in

primary care, with Professor Edwards similarly unable to find evidence of adequate pandemic planning [INQ000474283/14].

80. The evidence before the Inquiry shows that a failure to prepare and an underlying lack of resilience within the services was never overcome. Professor Edwards described a lack of initial policy and guidance and then a *"deluge"* when it finally came. As he highlighted "*there was a huge amount of documentation, generally important, sometimes urgent. The volume of documentation suggests a strong reactive element, and which would have been more manageable – leading to better quality responses in the service overall – if more of it had been proactive"* [INQ000474283/14]. Basic lack of capacity continued to plague NHS 111 and 999 services throughout the pandemic.

NHS 111: Capacity

81. In March 2020, DHSC placed NHS 111 at the centre of their Covid-19 response strategy. Rather than attending healthcare services in person, members of the public with Covid-19 symptoms were directed to call NHS 111. Whilst the aim of this strategy was to avoid the NHS becoming overwhelmed, there was insufficient capacity within NHS 111 to either meet demand or provide an adequate quality of advice to callers.

82. Diverting demand to NHS 111 should have made monitoring capacity within the service a priority for DHSC. Despite this, Sir Chris Wormald was unable to set out any steps that DHSC took to ensure that there was sufficient capacity. When asked, he deflected responsibility: *"It is the NHS's statutory responsibility to manage those things. The department discusses those issues with the NHS but it is their responsibility to manage capacity in all their services, of which 111 is an example"* [30/131/5-14]. This evasion does not withstand scrutiny. While the operational management of the service sat with the NHS, NHS 111 was no different to other areas of the healthcare system: the ultimate responsibility lay with DHSC. If DHSC had planned to have 111 as the central access point for its pandemic strategy, it should have ensured that it had capacity to be so and to scale up at pace. Plainly it had not and did not do so.

83. Mr Hancock told the Inquiry that he had *"regular briefings"* about NHS 111 [36/88/23-89/18] and DHSC had been regularly receiving data showing a high volume of calls being abandoned [INQ000339335]. However, there is no evidence that Matt Hancock in fact took any serious interest in NHS 111 capacity until his 'deep dive' briefings regarding NHS 111 in the week of 18.05.20, two months *after* he reassured the public that those who needed NHS care could continue to access it through NHS 111 [INQ000478891/2].

84. By May 2020, DHSC were aware that NHS 111 was woefully unable to handle the demand placed upon it in March-April 2020, with explicit recognition that 40% of calls had gone unanswered [INQ000409864]. However, the mood appears to have been optimistic, with DHSC noting that those figures had improved without any increase in capacity and there is scarce evidence of serious attention paid to the issue of increasing capacity between the first and second wave. This optimism was unsurprisingly misplaced. The next wave would find that NHS 111 was still unable to cope with demand [INQ000474285/17].

85. By the time Sajid Javid took over as health secretary in June 2021, NHS 111 continued to struggle to cope with demand. He described the lack of qualified call handlers to cope with NHS 111 demand as *"one of those [issues] that sort of stood out … one of the biggest issues"* [41/22/19-23/7]. This should have been considered a high priority issue for DHSC prior to and at least from the outset of the pandemic: the evidence before the Inquiry is that instead it was a problem which received little attention and was largely left to the NHS to manage.

NHS 111: Quality

86. In the five years before the pandemic, 20 deaths had been linked to failings in advice provided by the NHS 111 service.[3] During that period, several whistle-blower accounts and an undercover reporter had raised concerns about the inadequacy of training given to NHS 111 call handlers.[4] The BMA recognised in January 2020 that "*there is clearly much more to be done to ensure there is adequate assessment, expertise and support on hand for those who contact the [NHS 111] service."*[5] A Private Members Bill introduced in February 2020 called for a significant overhaul of the service, including clinical oversight and training standards for NHS 111 call handlers.[6]

87. In short, concern about the quality of advice provided by the NHS 111 service should have been well known to decision makers in March 2020, when the public were advised to rely on that service as the first point of call in response to the pandemic [INQ000389241/46].

---

[3] The Guardian, Kate Osamor, 23.03.20, *I warned Parliament that NHS 111 would never be able to cope,* url: https://www.theguardian.com/commentisfree/2020/apr/23/nhs-111-crisis-coronavirus-pandemic
[4] BBC News, 1.07.15, *South Central Ambulance inquiry after Telegraph report,* url: https://www.bbc.co.uk/news/uk-england-33345138
[5] The Daily Mail, 6.01.20, NHS 111 helpline is linked to more than 20 deaths in five years, including a two-year-old girl who was misdiagnosed with a stomach bug, url: https://www.dailymail.co.uk/news/article-7855135/NHS-111-helpline-linked-20-deaths-five-years.html
[6]Parliament UK, NHS 111 Service Training and Clinical Oversight Bill https://bills.parliament.uk/bills/2636

Quality assurance of that service should therefore have been a top priority for DHSC and NHS England.

88. While Sir Chris Wormald claimed that DHSC *"would have"* assured themselves that the NHS had quality assurance mechanisms in place to monitor NHS 111 services [30/129/23-130-7], there is no evidence of such mechanisms or DHSC's monitoring of them. The evidence given by Professor Stephen Powis in fact suggests a reactive role played by NHS England when ad hoc concerns were raised by others, rather than any proactive quality assurance mechanism [28/145/9-148/18]. Neither Health Secretary gave any evidence regarding monitoring, or even awareness, of problems with the quality of the service and the advice given. The Office of the Chief Medical Officer played no role in quality assurance of NHS 111 algorithms [12/219/5-21].

89. Despite the lack of monitoring of the quality NHS 111 advice, the problems with it were evident to those using the service. The Healthcare Safety Investigation Branch (HSIB) investigation began in October 2021 after concerns were raised by members of the public through its citizenship partnership [INQ000320204/20§2.1.1]. The findings of HSIB were damning, with simple service requirements such as the recording of calls not met. The essential structure of the system (that calls would be routed through the Covid-19 Response Service) was not implemented. The advice given to callers was deeply flawed. Tragically, the stories of many of the families we represent provide examples.

90. Lena Vincent lost her partner of 14 years, Patrick McManus, on 19 April 2020. Patrick worked as NHS Deputy Ward manager on an elderly care ward during the pandemic, even though he suffered from multiple sclerosis. During the week of 7 April 2020, his symptoms worsened, and he sought advice from NHS 111 on several occasions. The NHS 111 advice received was unhelpful, so much so that on the seventh day of symptoms, although Patrick's health was getting worse, NHS 111 told him that he could leave the house as he had *"passed the seven-day mark*".

91. Jane Roche lost her sister Jocelyn Pettitt to Covid-19 on 9 April 2020. Jocelyn was 54 years old. On 1 April 2020, Jocelyn began coughing uncontrollably and Jocelyn's partner rang 111 for advice. They were told not to worry as Jocelyn had a loose cough and that she should stay at home. She continued to feel unwell for the next few days and on the morning of 4 April 2020 her partner found her unresponsive. He immediately called an ambulance, and Jocelyn was admitted to the Good Hope Hospital in Sutton Coldfield with aspiration pneumonia.

92. Leigh Morgan-Jones lost her father Mr Ivor Arthur Frederick Morgan, on 3 April 2020. Leigh and Ivor experienced many problems with NHS 111 who advised that he *"would be better off if he stayed at home."* His symptoms continued to worsen. Ivor collapsed on the stairs in his home and cut his head. NHS 111 was reluctant to advise Ivor to attend at hospital and instead sent a nurse to the home to treat the wound. A nurse duly attended, reviewed his condition and recommended admission to hospital.

93. The stories above reflect two systemic failings within the NHS 111 system. Firstly, while 'safety netting' advice was in place to advise individuals to call back if their symptoms became worse, the outcome of such a call was often exactly the same. That a caller had made multiple calls was not apparent to the call handler and was not seen as a signifier of concern [INQ000320204/54§4.3.8]. Secondly, all Covid-19 related calls were supposed to be routed through the CRS system; however the CRS algorithm did not consider co-morbidities. Individuals with comorbidities would only receive clinical assessment if they were *"so ill that …[they've] stopped doing all of …[their] usual daily activities"* [INQ000320204/65]. Both of these failings were obvious and out of step with what was known about Covid-19 even in its early stages. Had steps been taken to assure the quality of NHS 111 advice, these issues would have been evident.

94. Professor Powis maintained that NHS 111 advice had been in keeping with what was known about comorbidities and was updated when further knowledge developed [28/33/1-39/3]. This was incorrect: the issue highlighted by HSIB was not the failure to consider particular comorbidities at the stage of clinical advice, it was the failure to consider comorbidities at all at the stage of *gatekeeping* clinical advice through the CRS triage system. Those with comorbidities as a group were not prioritised for clinical assessment. During the period of time that the HSIB investigation covered (March – June) it was well known that individuals with comorbidities were at a higher risk from Covid-19. The gap was not one of scientific knowledge, it was a systemic flaw in the CRS algorithm.

95. Even where individuals received clinical advice, there were clear problems with the quality of the advice. In October 2020, an audit by South Coast Ambulance Service found that in 60% of the calls it examined handled by the Clinical Assessment Service (CAS) within 111, the advice was unsafe. Professor Powis sought to downplay this report by pointing to what he described as the small sample size of the audit [28/148/1-19]. However, no steps were taken by NHS England to assess a larger sample size.

96. Following on from the alarming results of the audit, ten nurses involved in the service gave whistleblowing interviews to the media. They stated that the service was unsafe, highlighting that they had been offered their positions on the CCAS without an interview,

were given negligible training, no mentoring and inadequate supervision or support. They were given four hours' training in total before taking calls.[7] NHS England responded to the audit by removing nurses from the pool of clinical advisers, but no steps were taken to amend the training given to call handlers or clinical advisers regarding assessment of Covid-19.

97. Professor Powis maintained that the response to concerns raised by the audit was *"appropriate"* and that, having removed nurses from the pool of advisers, GPs did not need additional training. However, this did not turn out to reflect the experience of the GPs who were taking the calls, and he accepted that *"reflections in the HSSIB report [showed] that not everybody felt [the training] was what they needed, so I think that is definitely a reflection for the future"* [28/146/14-25]. Given the concerns which had already been publicly raised about training, there is no reason that this reflection should have been a matter of hindsight.

999 services

98. In research commissioned by the Inquiry, 45% of paramedics and 55 per cent of general practitioners said that one of the barriers to escalating care was access to an ambulance. 84% of paramedics reported having to act in a way that conflicted with their values in being unable to escalate care [INQ000499523/4]. Tracy Nicholls of the College of Paramedics described the situation in stark terms:

> *"Horrific… absolutely horrific… So, you know, if you put yourself in a patient's position of calling for an ambulance, being told that they can't guarantee when one is coming, and then calling back maybe an hour, two hours later, and still nothing's coming, the ambulance service can't give you an ETA because calls are coming in all the time and there may be a higher priority call comes in that pushes other patients further down the line in the queue which is a terrible state of affairs when the demand is so high. So the crews were very aware of not only a terrible patient experience of someone sitting in an ambulance with them outside the ED for hours, they were also acutely aware of all those patients who had not been seen by any healthcare professional waiting in the community and quite often deteriorating."* [9/72/22-74/19]

99. As set out in the evidence presented by Professor Snooks, ambulance delays did not improve after the peak of the pandemic, they worsened. Queues of ambulances waiting outside A&E became common place. Mark Tilley, a paramedic, gave an illustration of

[7] The Guardian, 10.10.20, *'It has been a trauma': nurses on 'shambolic' 111 Covid-19 clinical service* url: https://www.theguardian.com/world/2020/oct/22/it-has-been-a-trauma-nurses-on-shambolic-111-covid-19-clinical-service

waiting outside A&E in an ambulance for the duration of a 12 hour shift: "*We were there by 8 o'clock but when our shift had finished we were still there with the patient in the back of the ambulance. We had run out of oxygen so we'd had to scan the hospital to try to find oxygen. The consultant or doctor had been out to take bloods. Our patient had deteriorated quite heavily. It was a snowy, cold, icy day*" [14/14/1-7].

100. The triage of access to care brought in through the operation of Protocol 36 did not provide a safe solution to this lack of capacity. The implementation of Protocol 36 meant that those who were triaged as Covid-19 symptomatic would have been allocated a Category 2 response even if they were "*fighting for breath.*" This was self-evidently a dangerous measure and a belated NHS England safety review of the guidance in August 2020 recommended that the Protocol be amended [INQ000281180/4§21, INQ000470485/3]. Whilst this was implemented in September 2020, there was no investigation as to whether the protocol was tied to the increased phenomenon of patients being found deceased when crews arrived [INQ000410581/1].

101. Even where ambulances arrived, the environment was often unsafe due to a lack of properly tailored IPC guidance for the ambulance environment. This gap was raised by the College of Paramedics from the outset, and continued to be raised throughout the pandemic [INQ000257968, INQ000074820]. While decision makers gave evidence that it had been adequately addressed, Tracey Nicholls explained to the Inquiry that IPC guidance never developed in a way which enabled the protection of ambulance workers and the patients they were treating [9/54/14].

102. Partly as a consequence of this, the lack of availability of ambulances was compounded by an extremely high rate of workforce absence for paramedics and ambulance workers. This was also a reflection of the fact that prior to the pandemic ambulance staff had one of the highest rates of absence due to sickness due to stress and anxiety from across NHS services, a factor attributed to understaffing [INQ000474285/38].

Primary care

103. While witnesses told the Inquiry that GP services remained open throughout the pandemic, that was not the experience of many of our families in practice. For example, Tamara Howard describes the experience of her father Jeremy Howard, who died in May 2020. In the weeks prior to his death he had struggled to gain access to his GP. He tried repeatedly to get hold of his GP over a 3 week period and was unable to do so. He was eventually informed that his GP was closed and directed to another practice. He was only able to access advice over the phone and was unable to secure any kind of examination.

104. This struggle to access primary care was recognised by Professor Edwards who told the Inquiry that "*access and experience of access are deteriorating and frustrating for patients and staff alike*." His evidence painted a concerning picture of deteriorating resilience within primary care. He recommended that: "*Resilience in primary care is poor and needs urgent and substantial efforts to improve it, both to restore primary care to meet current needs which are outstripping capacity, and so that primary care can respond to pressures of a future pandemic on the scale of Covid-19. The workforce must be expanded in all disciplines – general practice, nursing and allied health, administrative groups.*"

SECTION FIVE: NOSOCOMIAL TRANSMISSION

Shielding and the impact of nosocomial infection

105. The critical importance of IPC guidance and implementation is highlighted by Professor Snooks' striking conclusion about an apparently separate topic, namely the effectiveness of the shielding programme. Professor Snooks and her team concluded that "*as long as healthcare associated infection was not under control, shielding could not be effective*" due to the high level of planned and unplanned contact clinically extremely vulnerable people had with healthcare services [INQ*474285/54, §157]. In her oral evidence, Professor Snooks explained that "whilst people might have been shielding from the neighbours, their friends, their families and so on, they were having such a high contact with hospital staff and healthcare practitioners that, whilst healthcare-associated infection was not under control shielding […] was not able to be effective" [/146].

106. It is recognised that shielding was a new intervention, developed in the early stages of the pandemic in an effort to identify and safeguard those who were most vulnerable to the poorest outcomes should they contract Covid-19. There was therefore no opportunity for planning of the shielding programme per se, but it was nevertheless clear that in any pandemic there would be a cohort of clinically vulnerable individuals requiring additional protection from the pathogen. The same holds true today and the learning of lessons in order to plan better for the next pandemic is crucially important.

107. This imperative is particularly strong given the sheer size of the clinically extremely vulnerable (CEV) and clinically vulnerable (CV) cohorts identified during the pandemic. As Professor Harries noted, a significant proportion of the UK's population were either CV or CEV, with around 17 million people deemed to be CV and around 3.8 million CEV and on the shielding list [27/69/15-70/1].

108. Professors Snooks, Harries and Whitty were all in agreement about the inherent difficulty in measuring the success of the shielding programme in achieving its stated aim of preventing mortality among those most at risk from Covid [27/6/16-23]. However, while Professors Harries and Whitty expressed scepticism about Professor Snooks' ultimate conclusion, we invite the Inquiry to note her oral evidence that this is a situation where it is impossible to carry out a randomised control trial, that the study she led was a large one, covering 130,000 shielding people and 130,000 comparators, and that she was taking the best evidence she could and felt duty bound to report the results available to her, while noting their limitations [23/149/24-151/1].

109. While noting Professor Snooks' conclusion that in light of her findings she and her team were unable to recommend shielding for the next pandemic, we suggest to the Inquiry that the proper conclusion to be drawn from her evidence is not that shielding does not work or should not be considered as a mechanism for protecting the vulnerable in a future pandemic. Indeed, Professor Snooks appeared to accept this possibility in her oral evidence, agreeing that there were positive aspects to the scheme in terms of support and observing that "*although shielding as it was implemented during this pandemic may not be appropriate […] there should be some consideration given to how people who are maybe eligible or need or wish to self-isolate, how they can do that because taking away shielding would be taking away all those benefits as well and I'm very aware of that*" [23/168/10-23].

110. Instead, we submit that Professor Snooks' findings indicate that preventing nosocomial infection should be at the core of any shielding or other strategy to protect the clinically vulnerable. It was clearly foreseeable that the CEV cohort would require higher than average contact with healthcare services and accordingly that they would be exposed to a greater extent to the risk of nosocomial infection while remaining vulnerable to any such infection. In our submission a central flaw of the shielding programme was the lack of any plan to implement additional safeguards for CEV individuals who did have to attend planned appointments or access healthcare on an emergency basis, both at the appointments themselves and in respect of transport.

111. It is also submitted that in view of the serious concerns expressed by the CEV about the abrupt ending of the shielding programme and its safeguards, it is necessary to reflect and plan from the outset how any future programme should be ended, ensuring that the "tailored" approach to ongoing risk assessment advocated by Professor Whitty can be delivered in practice [12/122/1-126/6]. .

Nosocomial infection – other considerations

112. We invite the Inquiry to reflect not only on the scale of nosocomial infection during the pandemic, as set out above, but also on the powerful evidence it has received from the bereaved and others about their lived experience of this phenomenon. In her evidence Dr Saleyha Ahsan made reference to such harrowing accounts, including the "horrendous" experience of a CBFFJ member, Andrew Ireland, and his wife Susannah who required hospital treatment for acute pancreatitis but acquired Covid-19 during that time. In Dr Ahsan's experience as a clinician this was a "constant, constant worry, of patients acquiring infection when they'd come for a different reason" [39/68/1-60/7].

113. James Telfer's mother, Jacqueline, acquired Covid-19 when she was admitted for testing for suspected Myeloma. Prior to going to hospital, she had carefully isolated and tested negative several times. She then acquired Covid-19 whilst waiting in A&E. The hospital twice failed to test for Covid-19 whilst she was an inpatient despite it being clearly printed on the patient care booklet as a mandatory test. She died in January 2021.

114. Tamera Howard lost her father, Jeremy, on 24 May 2020. On 30 April 2020, he was admitted to Royal Derby Hospital with a pulmonary embolism. He tested negative for Covid-19 on admission but was still placed on a Covid-19 positive ward. He was eventually moved to a side room following requests from Tamera, however, whilst there, he tested positive for Covid-19.

115. Claire Mcilwaine lost her mother, Eileen Mash, in May 2020, after she was admitted to hospital following a fall. She was placed on a crowded ward with insufficient space for social distancing and with healthcare staff from multiple specialties moving through the ward. There was an outbreak of Covid-19 on ward. Eileen was one of 8 patients who lost their lives as a result.

116. These experiences must be the prompt for action in advance of the next pandemic to prepare for and minimise the risk of nosocomial infection.

117. In addition to the specific concerns outlined at Section 3 in relation to the formulation of IPC guidance and the use of FFP3 respirators, we also emphasise the environmental factors which increase the risk of nosocomial infection in the UK and which must be addressed. These are helpfully summarised by Professors Shin, Gould and Warne in their report as factors where "*the hospital environment facilitated transmission*", notably hospital ventilation systems in older hospitals which do not meet modern standards; the relative lack of isolation side room capacity - especially HEPA-filtered, negative pressure, lobbied side rooms, and ward designs which are open-plan and not well segmented [INQ*474282_123 §11.41].

[Return to contents]

118. The expert evidence on this point is reinforced by evidence the Inquiry has heard from clinicians working in these conditions, including by witnesses from the spotlight hospitals: see Professor Ball's acknowledgment that the relatively low rates of nosocomial transmission at QEB benefited from the largely modern estate of his own hospital, which he contrasted with the crowded late 19th / early 20th century hospitals elsewhere in his Trust [28/30/2-11]; Dr Kloer's evidence about the limiting factors associated with the infrastructure of Glangwili Hospital, which was opened in 1959 [30/135/8-136/24]; and Professor McKay's evidence about Glasgow Royal Infirmary, where many of the wards were built in the 1920s and 1930s and remain very much as they were at the early part of [that] century [23/1/23 – 2/5].

119. We urge the Inquiry to address these factors robustly in its findings and recommendations, noting the above evidence and that of Professor Banfield, who told the Inquiry that "the medical profession as a whole still feels that its worries about infection control and respiratory protection, ventilation in the hospital estates, is still unheeded and therefore we are unready for the next pandemic [21/119/18-22]. The evidence on this issue is one illustration of the vital importance of our submissions at Section 1, above, on resources and capacity.

SECTION SIX: DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

120. Inappropriate DNACPR use is far too common a feature within the stories of Covid-19 bereaved families, including at least **422** of those we represent, further compounding their grief and raising serious questions over the UK healthcare response.

121. This was a systems failure. There was a widespread lack of clarity and consistency in DNACPR guidance, training, messaging, interpretation and implementation. This much is clear from the CQC's interim report in November 2020 which found evidence of overwhelmed providers and "*confusion, miscommunication… unacceptable and inappropriate DNACPRs … at the start of the pandemic*" [INQ000466466].

122. Worse still, this was not a new issue. Sir Christopher Wormald told the Inquiry that "*there was a low level of concern, of which everyone was aware prior to the pandemic, that the good practice was not always followed*" [30/62/12-15]. Why then, if "*everyone was aware*", was nothing done to address inappropriate DNACPR use? Covid-19 exacerbated and accelerated this already accepted form of structural discrimination.

Blanket DNACPR Use and Frailty Scores: A culture of confusion

123. The NICE guidance published on 20 March 2020 caused widespread confusion about the use of clinical frailty scores, DNACPRs and care provision.

124. Prof Wyllie spoke of a Trust that implemented a blanket DNACPR on the basis of age, disability and condition. Dr Kloer noted concerns raised in a spotlight hospital in February 2021 of DNACPR notices being issued for Covid-19 patients with learning disabilities without their consent. Jean White and Jackie O'Sullivan gave evidence of GP practices sending letters to groups of patients to encourage them to sign DNACPRs. Dr Mulholland said "*some GPs were being asked to do frailty scores on either patients in care homes or their elderly, vulnerable or more ill patients*" [9/169/9-25]. These were not isolated incidents, but widespread examples throughout the UK, as acknowledged by Professor Powis: "*we had heard enough examples of it to be concerned.*" [28/102/5-15].

125. Hurried attempts were made to reiterate the proper guidance, such as the joint BMA/CPA/CQC/RCGP statement on 30 March 2020 that "*It is unacceptable for advance care plans, with or without DNAR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need."* [INQ000192689]. But not only were these statements insufficient they were themselves a distraction, with Professor Wyllie saying that it caused RCGP to lack the "*bandwidth*" to take up specific concerns with the Trust involved or NHS authorities [20/23/19-21].

126. The culture of confusion and blanket DNACPR use continued for at least another year, with questions raised in Parliament causing the Minister for Social Care to request "*a method of assessing the scale of inappropriately applied DNACPRs*" in September 2020 [INQ000478907]. This is also evident from Dame Ruth May's evidence that "*there were still further reports coming through*" in March 2021 [6//80/20-21].

Inadequate Consultation & Inappropriate DNACPRs: A 'doctor knows best' mentality

127. For many of the family members we represent, their question is a simple one: how and why was a DNACPR notice issued without consultation or against the patient's wishes? Dr Suntharalingam said: "*There may have been some slipped through the net [without consultation], but it wouldn't be the normal case*" [19/36/11-13]. However, the stories from bereaved families paint a different picture — one of widespread occurrence:

i. **Sarah Choudhury** lost her mother Khudeza Choudhury on 25 October 2021 and found out that a DNRCPR had been placed on Khudeza without her knowing or having the chance to discuss it with a medical professional.

ii. **Julie Bayley** lost her husband Anthony (Tony) Bayley on 15 November 2020. During Tony's stay in the ICU, Julie was contacted about a DNACPR decision but did not agree this was the best decision for Tony. When Julie received the hospital notes it was wrongly written that Julie had agreed to the DNACPR on this phone call.

iii. **Anne Steadman** lost her father Frank (Francisco) Nunes on 27 March 2020. Frank was 79 years old, and on 6 March 2020 he was admitted to the I&S I&S following an ultrasound as he was suspected of having cancer. A DNACPR decision was made on 27 March 2020. According to the hospital, this decision was taken due to Frank's "frailty and underlying cancer." Anne confirms that a doctor called her roughly an hour before Frank died on 27 March 2020 to advise her as to the DNACPR. This is in contradiction to what Frank stated and Anne witnessed whereby on the day of admission, a DNACPR was discussed with Frank with Anne present, and Frank confirmed he would want to be resuscitated. The medical records note that this was further reiterated on 9 March 2020.

128. The Inquiry also heard from Jackie O'Sullivan about a phone call, overheard by a MENCAP support worker, that went along the lines of "'*I'm just calling from the doctors to see if it is okay to put a DNACPR on your file' and when the person said, 'What's that?', the doctor said, 'Well, you know, it is nothing to worry about but if something bad happened to you they wouldn't give you the kiss of life', to which the person replied, 'Well, I wouldn't want that because I might catch Covid' and that was the end of the conversation*." [21/68/1-17].

129. These examples paint a picture of a 'doctor knows best' mentality — all too often encouraging, coercing or simply applying a DNACPR without proper explanation, involvement or meaningful consultation.

DNACPRs as a Proxy for Broader Treatment Decisions: The elephant in the room

130. The culture of confusion did not stop with issuing of DNACPR notices. The evidence shows that DNACPRs were being used as a proxy for broader treatment decisions and interpreted as imposing a care ceiling. This again, was an issue that should have been well known to decision makers prior to the pandemic. As Professor Summers and Dr Suntharalingam explain, while a DNACPR order should apply only to the act of CPR itself, qualitative, pre-pandemic evidence showed that the presence of a DNACPR order can influence other treatments in acute medicine [INQ000474255/24§56].

131. The potential for trend of DNACPR notices to operate as a ceiling of care during the pressure of a pandemic was clear. Despite this, NICE guidance included a paragraph on DNACPRs in a section called "Admission to Critical Care" [INQ000315780]. Worse still, the guidance told medical professionals that a "*sensitive discussion*" of DNACPR decisions should include a discussion of the possible benefits and risks of critical care treatment options [§2.4]. At no point did the guidance state that a DNACPR notice should not be conflated with other decisions relating to critical care. The confusion appears to have started at the top. Matt Hancock's evidence suggests that he himself saw DNACPR as *"part and parcel"* of the escalation of care through other treatment [36/43/16-20].

132. The consequence of this in the pandemic was articulated by Jackie O'Sullivan: "*[a DNACPR notice] doesn't mean that they are signing away their rights to any treatment at all and that's, in practice, what was happening, that people were not getting treatment, they were not getting conveyance to hospital.*" [21/7/5-10].

DNACPRs: Conclusion

133. Doctors were undoubtedly working in extremis, and faced their own professional, ethical and psychological challenges during the pandemic. But the imposition of inappropriate and blanket DNACPRs was wholly wrong, and cannot be justified by the pressures they were under. The consequence of DNACPRs being inappropriately applied against a patient's or family member's wishes may have been fatal. These decisions led directly to the lack of treatment and loss of our family members' loved ones. That is a failure of the UK healthcare systems which must never be allowed to happen again.

134. But sadly, the UK healthcare systems appear destined to not learn from this failure. Sir Christopher Wormald's candid admission that the "*biggest action we took was commissioning the [CQC] report*" [30/69/2-16] shows that DHSC was happy to wash its hands of responsibility for DNACPRs. Professor Gregor Smith was unable to even explain why there had been no review undertaken in Scotland. Sir Michael McBride accepted that "*we have much further work that we need to do*" in Northern Ireland [10/173/7-8].

135. It is not enough to reiterate guidance and issue reactive statements when concerns arise. There must be proactive action and a change in culture to ensure that the DNACPR failure is not repeated.

SECTION SEVEN: STRUCTURAL AND INSTITUTIONAL DISCRIMINATION

136. As Inquiry experts Professors Marmot and Bambra outlined in Module 1, the UK entered into the pandemic after a decade where health inequalities had increased and health among the poorest people was in a state of decline [INQ000195843/29§58]. Structural and institutional discrimination had been largely ignored throughout the decade preceding the pandemic, as Ade Adeyemi of FEMHO explained, *"deep rooted structural problems are never seen as proximate enough, in urgent conversations about emergency planning. The Covid-19 pandemic has proven this thinking to be deadly wrong"* [INQ000174832/1§2].

137. The impact of this state of affairs on the healthcare system going into the pandemic was well known. In February 2020, the concern amongst healthcare professionals was such that all medical and nursing Royal Colleges and Faculties joined together in forming the Inequalities in Health Alliance. They wrote to the Prime Minister highlighting the findings of *The Marmot Review: 10 Years On* which had found not only that life expectancy had stalled for the first time in at least 120 years, but that there was a 15-20-year difference in healthy life expectancy between different areas of the country, reflect socio-economic disadvantage [INQ000319648]. As the letter highlighted, *"[t]hese disparities directly impact on NHS services, with emergency attendances doubling in the areas of lowest life expectancy."* As well as urging the adoption of a cross government strategy to address health inequality, the letter recommended raising the national living and working wage, recognising poverty as one of the contributing causes to health inequality.

138. This reflects a fundamental aspect of the evidence that the Inquiry has heard in Module 3: inequalities within the healthcare system cannot be addressed without addressing structural socio-economic disadvantage within our wider society. As Professor Whitty acknowledged *"poverty is a risk factor for infections everywhere"* [12/159/9-15]. As he failed to recognise [12/159/16-18], the predictable confluence of socio-economic factors meant that greater risk according to ethnicity was equally as predictable. Whilst this Inquiry will not be able to tackle structural and institutional discrimination within our society, it cannot ignore their relevance to inequality within the pandemic response by the healthcare system.

139. Addressing discrimination and inequality should have been at the forefront of decision makers' minds in responding to the pandemic. The evidence in Module 3 shows that it was

not: it was treated as an afterthought and entrenched by policies and guidelines which discriminated against vulnerable groups. This absence of consideration was a reflection of the institutional racism highlighted by Professor Nazroo in his evidence to the Inquiry in Module 2 [PHT000000026/19].

140. The discrimination within NHS 111, 999 and primary health services illustrates this. There had been a lack of any pandemic planning for different patient groups such as older persons, people with multiple conditions, neurodiverse persons or persons from minoritised ethnic patient groups [INQ000474283/14§61]. While it was well known (and continues to be the case) that minoritised groups have less access to and satisfaction with GP services, no steps were taken to address and mitigate this structural inequality.[8] NHS 111 and 999 algorithms made matters worse through framing questions with the presumption that callers would have white skin.

141. This failure was not coincidental, but the result of structural discrimination being treated as an afterthought in the design and structuring of services. It was clear that decision makers were aware that they were under a duty to consider these issues: in a briefing to Anthony Marsh (National Ambulance Coordination Centre, NHS England) in April 2020, it was stated that there had been "*no formal impact assessment under the Equality Act"* but that *"the issue of vulnerable groups continues to be monitored and discussed at appropriate groups, e.g. NASMeD on 2 April"* [INQ000410621/8]. The minutes of that meeting contain no note of any assessment of the impact of triage on vulnerable groups [INQ000472352] and there is no evidence of any such assessment.

142. A similar approach is evident in the development of the Critical Care in Adults guideline, published by NICE on 20.03.20 [INQ000474301]. The guideline was very obviously discriminatory and could result in fatal adverse decisions for those with learning disabilities, as was raised immediately upon its publication by Jackie O'Sullivan of MENCAP [INQ000228378]. As Paul Chrisp accepted on behalf of NICE, the failure to recognise this was due to a failure to conduct a thorough equalities impact assessment due to the speed of production required for the guidelines [23/81/1-25]. While this guidance was subsequently amended, as Jackie O'Sullivan explained to the Inquiry, the damage had already been done, and evidence from MENCAP shows that guidance had permeated the Health Service [23/79/1-22].

[8] The Guardian 15.02.24, Ethnic minorities in England have worse access to GPs, url: https://www.theguardian.com/society/2024/feb/15/ethnic-minorities-in-england-have-worse-access-to-gps#

143. These examples reflect an assumption on the part of decision makers that a proper equality impact assessment is not an indispensable and necessary part of policy making, but an optional aspect that can be diluted or omitted entirely. This in itself is a reflection of the institutional discrimination that contributes to such policy making. Equality should never have been side-lined as a lower priority - it should have been embedded as a central pillar of pandemic planning and response.

144. The Inquiry should recognise that although different forms of discrimination may overlap or intersect, they should be addressed as distinct issues. For example, the issues facing those from minoritised ethnic groups were not the same as those facing older people. Each group deserves proper consideration by the Inquiry reflected in specific findings and recommendations. Recommending a single approach to 'vulnerabilities' is not appropriate or sufficient.

Structural and Institutional Racism

145. The disproportionate impact of the pandemic on ethnic minorities was recognised by decision makers early on, following the publication of ICNARC critical care data on 5.04.20 which showed that a disproportionate number of people who were not white had been admitted to critical care [INQ000099539]. It is telling, however, that this data was not requested by the government. As Professor Kathy Rowan told the Inquiry, ICNARC had itself recognised this trend from media reporting and provided the 5.04.20 data on its own initiative [15/22/16-23/22]. It was only after this that the Race Disparity Unit in the Cabinet Office contacted ICNARC [INQ000198896/7]: once again, an afterthought and a reflection of institutional racism.

146. For this Inquiry, the challenge is not just to understand these failures but to act upon them. Structural discrimination is not simply an abstract concept or a theoretical issue - it is a matter of life and death. This is not about "othering" BAME workers or patients. The problem is not theirs to solve; it lies squarely at the feet of societal and institutional structures. The pandemic may have exposed these inequities, but they have existed for far too long, and it is imperative that this inquiry ensures that the failures of the past are not ignored, or that structural and institutional issues are considered too big or beyond scope, but that they are robustly addressed now.

147. While Matt Hancock accepted that systemic racism was prevalent in the NHS before the pandemic, the Inquiry may wish to consider whether this acceptance simply paid lip service to an undeniable truth rather than reflecting a sincere understanding and prioritisation of the issue. His opinion that the solution is to *"treat everybody as an equal"* [36/189/8-190/21] reflects a fundamental misunderstanding of the nature of structural racism. One of the impacts of structural racism within the NHS is that workers from minoritised backgrounds are not equal, they are disproportionately employed in 'lower ranking' roles, and in the pandemic they had disparities of outcome.

148. Dr Philip Banfield gave evidence that ethnic minority doctors face systemic discrimination within the NHS, being less likely to progress in their careers, more likely to face bullying and harassment, and disproportionately referred to the General Medical Council (GMC). These issues existed long before the pandemic but were laid bare by the crisis, exposing inequalities "*like no other situation*" [21/139 & 140/25-7 & 14-17]. Dr Banfield further noted that ethnic minority practitioners often began their NHS careers "*on the back foot*," lacking proper induction and support to practice safely [21/167-168/21-22].

149. 'Hostile environment' policies further compounded these challenges, creating impossible choices for many migrant workers. Alex Marshall told the Inquiry that workers on precarious visas, particularly those from the Philippines, were under significant pressure because their right to stay in the UK was tied to their employment. Mr Marshall described how these workers feared that pushing back against unsafe or exploitative working conditions could lead to job loss - and, consequently, visa termination. "*It's not a choice*," he said. "*You have to just continue*." Many workers had no option but to keep working despite illness or dangerous conditions because they lived paycheck-to-paycheck, and missing even a single day of work could destabilise their financial situation for weeks or months [20/58-60/5-3].

150. The 'hostile environment' also exacerbated broader vulnerabilities. Migrant workers were often forced into overcrowded housing and dangerous working conditions, leading to heightened stress, isolation, and mental health problems. These policies also deterred many migrant workers from testing and seeking healthcare. Mr Marshall detailed how even those who were entitled to healthcare access were often too scared to use these services, fearing deportation or being deemed unwelcome. This fear reflects how deeply entrenched the 'hostile environment' has become systemically, creating barriers to care for some of the most vulnerable individuals [20/60/2-24].

151. The consequences of these systemic failures were not confined to healthcare workers; they also extended to patients. For example, during the pandemic's first lockdown, there was a marked decrease in mental health service admissions for BAME children and young people, as highlighted by Dr Guy Northover. This decrease reflected barriers to accessing early interventions, which later resulted in more severe cases requiring higher levels of support during the second lockdown [24/152/5-25].

152. Structural racism is compounded by discriminatory practices baked into the system. Examples include failures in clinical algorithms, PPE design, and medical devices.

153. In terms of clinical algorithms, NHS 111 relied on questions like "*Have your lips turned blue?*" - an indicator that might work for white patients but was wholly inappropriate for darker-skinned individuals. This oversight raises serious concerns about whether services such as NHS 111 were equipped to cater to diverse communities or whether institutional racism played a role in ignoring these needs [1/29/15-25].

154. Issues with PPE disproportionately affected ethnic minority HCWs. Rozanne Foyer, General Secretary of the Scottish Trades Union Congress, stated that FFP3 masks were often designed for male faces, disadvantaging women and ethnic minorities. This was a consistent issue raised by healthcare unions [5/55/13-23].

155. Another example was the use of pulse oximeters, which were less accurate on patients with darker skin tones. This issue had been documented for over 30 years but remained unaddressed. As Professor Habib Naqvi explained, the lack of diverse representation in clinical trials often leads to the development of medical devices that are unsuitable for diverse populations [20/107/18-25]. The result was delayed hospitalisation and treatment for patients of colour, directly impacting survival rates [1/29/11-21].

156. Professor Habib Naqvi gave evidence that 83% of HCWs who died during the early stages of the pandemic were migrants, reflecting the disproportionate burden borne by this group [20/135/16-23]. These workers were often placed in high-risk frontline roles with inadequate protections, highlighting a lack of systemic accountability for their welfare.

157. Rather than mandating protective measures, the NHS relied on individualised risk assessments, leaving BAME workers to advocate for their own safety, and ignoring structural and institutional issues. A June 2020 survey revealed that more than two-thirds of ethnic minority pharmacists had not received a Covid-19 risk assessment nearly two months after the NHS mandated them [1/61/3-10].

158. This was powerfully reflected in Dr Tilna Tilakkumar's evidence. She recalled an incident where a visiting manager pulled a plastic apron from a healthcare assistant (HCA) because PPE requirements had been downgraded to apply only when dealing with confirmed Covid-19 positive patients. The HCA, terrified of contracting Covid-19, had chosen to wear full PPE despite these changes. As Dr Tilakkumar told the Inquiry, the HCA was Black and the manager was not. This occurred in a mental health trust that was ill-prepared for managing physical illnesses or infection prevention. Dr Tilakkumar detailed how this created significant stress and anxiety among staff, exacerbated by the national PPE shortages and a perception that the Trust was trying to conserve PPE supplies [14/118/18-119-16, INQ000492278§40].

Age

159. Ageing is a universal experience. Its interaction with other risk factors and characteristics is often overlooked, but risks associated with ageing have to be viewed in light of circumstances and characteristics that accumulate or amplify risk, such as race/ethnicity. Death rates from Covid-19 were higher among all ethnic minority groups (except the Chinese community) and highest in black Caribbean men aged 65+ where the death rate was 2.3 times higher than in white men of the same age range.

160. It was clear that lockdowns and social distancing would adversely affect older people disproportionately. Many would be frightened to seek NHS advice when needed, especially those who lived alone or relied on family or neighbour support, and who were physically and digitally isolated. In those early weeks, on the evidence, no one from government reached out to Age-UK, so there was a missed opportunity to listen to the lived experience of older people.

161. Older people were more likely to (a) have needs that required close contact with a carer, (b) live in congregate settings where the virus spread like wildfire, and (c) have pre-existing conditions that increased morbidity and mortality. They were more likely to rely on the NHS, and older people bore the burden both of infection risk and of service disruption to, for example, cancer services. Caroline Abrahams from Age-UK noted that the least advantaged older people have therefore been hit with a "*triple whammy*" where age, underlying health status and life circumstances increased the impact of the pandemic on older people's health [INQ000319639/5§18].

162. As much of the country went digital in response to social distancing and under the banner of the imperative to "Protect the NHS", many older people were left out. Many struggled with how to reach their GP if not in person. Half of people over the aged of 65

did not use a smartphone, and 3.4 million of them did not use the internet, including 46% of people aged 75 [INQ000319639/8§26].

163. As accepted by Professor Whitty, even before the pandemic reached the UK, the high risk faced by older people was certain and publicised [12/158/23-159/2].

164. There are more than 10 million people aged 65 and older in England: almost 1 in 5 of the population. ONS data showed that in April 2020, at the height of the first wave, one in eight people over 90 years old died from Covid-19, compared with less than two in 50,000 aged between 20 and 24 [INQ000221437].

165. It was older patients who fared worse, and whose needs were inadequately considered. The evidence of Professor Banfield from the BMA was that older consultants were particularly vulnerable to morbidity (including long Covid) and mortality [INQ000477304 §182-4].

166. Discrimination against older people was prevalent across the healthcare system. While Module 3 did not consider the social care sector, we support the position of Age UK, that to "*a great extent caring for the health of many older people makes health and social care services indivisible in practice*" [INQ000319639/13§44]. This inter-relation contributed to the impact of structural discrimination by restricting older people's access to healthcare services.

167. There was significant pressure to discharge patients from older adult wards to care homes even where discharge was too early [INQ000417461/64]. At the same time, Age UK received reports of older people in care homes being left to die of Covid-19 and other illnesses without sufficient clinical support or sometimes access to palliative care teams or palliative care medicines. Care staff were left without enough back up support from GP and community based palliative care services, and without the possibility of older people being admitted to hospital [INQ000319639/14§46].

168. Resource pressures on the healthcare system disproportionately affected older people. ICNARC data reflected the disproportionate impact in relation to their access to critical care beds [INQ*474239, INQ*474255]. DNACPRs were disproportionately used as a ceiling of care. Indeed, one of the reports which prompted NHS England's belated concern about DNACPRs had been the blanket imposition of notices on all those above 80 with dementia [INQ000381156/4].

169. The issues of discrimination against older people in Module 3 cannot be separated from the attitudes of decision makers in relation to their approach to the pandemic as a whole. As was clear from the evidence in Module 2, the UK's approach to Covid-19 treated older people as being expendable. Sir Patrick's diary entries noted in relation to the Prime Minister: *"he is obsessed with older accepting their fate and letting the young get on with their life and the economy going"; "PM says... Covid is just nature's way of dealing with old people"* [INQ000273901/150;308]. Against the backdrop of this leadership and national approach, it cannot be a coincidence that older people were disproportionately denied access to critical care.

Mental health

170. The pandemic has had a profound impact on the country's mental health. For those who had pre-existing mental health conditions, it was even worse, given the social isolation, prohibitions on contact with others and the shut-down of places in the community that people gathered for support, whether that be a clubhouse or church, supermarket or café. One study found that people with serious or severe mental illness were almost five times more likely to die during the pandemic than people without severe mental illness. Prof Summers described the mental health impact on HCWs as "moral injury" [19/68/10-15].

171. We have addressed above serious issues regarding the treatment of clinical patients with learning disabilities, autism, and Down syndrome. Other CPs have specific expertise and experience to focus on the effects of the pandemic on mental health services. However, of particular importance to CBFFJ UK members, and to many thousands of bereaved families across the UK is access to bereavement counselling. Accessing such services was problematic before the pandemic, as there were long waiting lists to access scarce services.

172. During the pandemic, none of the four nations increased bereavement services to match the sudden increased need for such services. The natural devastation of bereavement was compounded by questions around cause of death in death certificates, the regular refusal of coroners to hold inquests into the deaths of people who had died of Covid-19 as these were "natural deaths"; the restrictions on visiting loved ones in funeral homes, and the severe restrictions on rituals and attending funerals, and on social gatherings after funerals. Some bereaved were impacted in the failures of RIDDOR, including that ethnicity was not required to be reported, so that BAME families did not have

the confidence that ethnicity would be recorded and factored into any analysis. More broadly, there was no mechanism in any of the four nations to record HCW deaths.

173. The sudden increase of bereaved people has been described as *"a silent epidemic of grief"*, and a survey of 805 specialist respondents caused scholars to observe that "the pandemic created major challenges for the support of bereaved people: increased needs for bereavement care, transition to remote forms of support and the stresses experienced by practitioners, among others. The extent to which services are able to adapt, meet the escalating level of need and help to prevent a 'tsunami of grief' remains to be seen. The pandemic has highlighted the need for bereavement care to be considered an integral part of health and social care provision". [9]

174. The first witness in M3 was John Sullivan, the impact witness from CBFFJ UK. He told the inquiry that after the death of his beloved daughter Susie, he and his wife were not offered any bereavement counselling [INQ000489906/7]. In maternity units, where some parents sadly experienced the death of their baby, the Inquiry heard evidence that women and their partners could not access effective bereavement care without either face-to-face support from specialists or from friends and family.

175. Judith Paget of the Welsh Government told the Inquiry that in its March 2023 interim learning report [INQ000413883/6] the NHS national nosocomial Covid-19 programme in Wales identified that bereavement services were extremely important to those who had lost loved ones. Since the pandemic a national bereavement pathway has been developed by the NHS in Wales, although the evidence was less clear as to how it is to be assured [35/187/25 - /190/12].

176. A bereavement pathway did not exist in England, Scotland or NI. Michael McBride (NI CNO) told the inquiry that, *"we must do better in health social care around bereavement care and bereavement support"* and that this became clear from when restrictions were put in place around funerals [10/29/6].

Disability

177. The Inquiry has heard much evidence on the myriad ways in which the pandemic affected disabled people's healthcare. Daily public health briefings at No. 10 Downing

[9] Pearce C, Honey JR, Lovick R, *et al* "A silent epidemic of grief: a survey of bereavement care provision in the UK and Ireland during the COVID-19 pandemic" *BMJ Open* 2021;**11**:e046872. doi: 10.1136/bmjopen-2020-046872

Street were not signed or available in EasyRead formats. Government guidance was often inaccessible to people with visual impairments or learning disabilities.

178. John Sullivan gave a powerful example of disability-based discrimination. He told the inquiry that his daughter's Down syndrome was recorded as a reason for the decision not to admit her to ITU. He said, *"She struggled with tolerating an oxygen mask, yet the learning disability team was apparently not deployed to help her, nor were her family allowed to attend to help, which could have made a critical difference."* [1/133/13-20]. Hospitals ought to recognise family members of disabled patients not only as visitors, but as offering support and aid to communication between the patient and their clinicians: as key caregivers. In future public health emergencies, relatives of disabled patients should be designated as such to give them status to distinguish them from an ordinary visitor who might, for public health reasons, be barred from visiting save for end of life.

179. The Inquiry heard evidence that there was considerable confusion about frailty scores. Dr Suntharalingam observed that clinical frailty scores could be misused if a person with a learning disability required a carer for a non-frailty reason (such as to meet eligible needs under the Care Act). They may become labelled as a person who is 'frail', and thereby denied services. Disability and frailty are very distinct and should be clearly recognised as such.

180. ONS data from February 2021 showed that 46% of disabled people said the pandemic had a negative impact on their mental health, compared with 29% for non-disabled people.[10] The same report noted that disabled people more often indicated Covid had affected their life than non-disabled people in ways such as their health (35% for disabled people, compared with 12% for non-disabled people), access to healthcare for non-Covid related issues (40% compared with 19%), well-being (65% compared with 50%) and access to groceries, medication and essentials (27%). The Health Foundation also reported that disabled people were more likely to report that Covid restrictions had a negative impact on their lives.[11]

181. The evidence showed that those with disabilities fared much worse in the pandemic. In large part this was because their specific needs were not recognised or addressed.

Data

---

10 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/coronavirusandthesocialimpactsondisabledpeopleingreatbritain/february2021.

11 https://www.health.org.uk/news-and-comment/blogs/the-forgotten-crisis-exploring-the-disproportionate-impact-of-the-pandemic

182. The pandemic has exposed the longstanding inadequacies in data collection and analysis within the NHS, particularly regarding ethnicity. Poor data collection undermined the NHS's ability to understand and address the disproportionate impact of Covid-19 on ethnic minority groups.

183. Professor Habib Naqvi highlighted the NHS's "patchy" data practices, describing how inadequate recording of ethnicity left the healthcare system "flying blind" in its attempts to fulfil its moral and legal obligations. He explained that simply ascribing people to broad racial categories was insufficient for meaningful analysis [20/118-119/18-25].

184. This problem extended to ambulance services, as Professor Helen Snooks revealed. Ethnicity data was often missing from patient records, both at call centres and on the scene. In some cases, ethnicity was recorded for white British patients but left blank for others. Snooks noted that this failure made it difficult to assess the pandemic's impact on ethnic minorities or address their specific needs [23/131-132/13-21]. Dr Paul Chrisp in his evidence acknowledged that such data would be "helpful" [23/123-124/22-2].

185. In Wales, the ONOMAP tool used to identify ethnic groups from names proved deeply flawed. As Professor Fu Meng Khaw explained, the tool's predictions were less than 50% accurate for Black or Black British individuals, limiting its utility in understanding the pandemic's effects on these communities [26/21/15-25].

186. Northern Ireland also had significant deficiencies. Aidan Dawson gave evidence detailing that ethnicity and disability data were not tracked, leaving public health agencies unable to assess the pandemic's impact on minority groups. Dawson admitted that this lack of focus on ethnicity or disability persisted throughout the pandemic, with little effort to correct it until recently [26/73-75/17-17].

187. The implications of this are summarised by Professor Metcalfe, who states as follows: *"So we know there was a relationship with social deprivation and we know that both ethnic minority -- proportions of ethnic minorities and social deprivation are two interlinked -- are often interlinked, so it is likely that there was. We don't have data on that and perhaps similar to the point that was being discussed earlier about granularity of data, then actually granularity of data in terms of ethnicity, gender, social deprivation, would be valuable if there was a way of making that available and that would improve our ability to -- because ultimately the availability of data allows you to act in a more targeted way and motivate change, so I think that sort of granularity of data would be really valuable."* [24/100-101/18-8].

188. One of the few areas with robust data was intensive care units. Professor Kathryn Rowan OBE noted that ICU data captured key factors such as age, advanced chronic conditions, ethnicity, and deprivation. Reflecting on this she stated: *"I think when you put all that data together, age, advanced chronic conditions, ethnicities, deprivation, and wider reading of what was going on during the pandemic, it does suggest health inequalities. And health inequalities are, sort of, avoidable, unfair and systemic differences in health between different groups of people, including differences in life expectancy, behavioural risks, access to and availability of health and care services, and the quality and experience of care, and I think it's important for us to really focus on health inequalities, because I think they really come - they are really magnified during conditions such as a pandemic."*

189. The lack of reliable data during the pandemic was not just an oversight; it reflected systemic disinterest in understanding and addressing disparities. Accurate, intersectional data is critical for informed public health policy, and its absence during Covid-19 hindered the NHS's ability to protect vulnerable groups.

190. Issues of structural and institutional racism did not arise as a result of the virus but their effects were both highlighted and exacerbated by the pandemic. Whereas the Inquiry is not capable of removing these systemic problems altogether, it would fail in meeting its Terms of Reference if it did not recognise the significance of racial discrimination and its dire adverse effect on outcomes for both BAME healthcare workers and patients in the emergency, and make recommendations to address discrimination for the future.

SECTION 8: NORTHERN IRELAND DEVOLVED ISSUES

191. Against the background of the submissions above, being of general application to the health care response in England and across the UK as a whole, we make the following specific observations relating to the healthcare response in Northern Ireland.

Lack of self-reflection on pandemic performance

192. At the outset we consider it appropriate to identify systemic issues which appear common to many of the issues already outlined. The most notable, in the Northern Irish context, is the apparent lack of self-reflection, or any meaningful evaluation of what went wrong with the NI healthcare response. The stark absence of reflection in much of the NI statements and oral evidence before the Inquiry in M3 is of acute concern to NICBFFJ. Critical evaluation of the healthcare response, of what was done well and what needs to be changed or improved or better understood, is a precursor to ensuring that Northern

Ireland residents are better served and protected in a future pandemic – and yet, in Northern Ireland, it has yet to meaningfully commence.

193. By way of example:

(i) There was an absence of evidence of any detail from key NI witnesses on the impact of the mistaken definition of droplet size, primarily among medical scientists as opposed to physical scientists, and the consequences of that mistaken understanding for measures taken to prevent transmission;

(ii) Relatedly, there was a lack of detailed evidence on when it should have been considered that the virus was transmitted near field or far field, and if far field, whether IPC guidance (or any other guidance or policy) should have changed sooner;

(iii) There was a failure to consider and address concerns about data collection in a manner that would allow comprehensively informed answers. NI witnesses were apparently taken by surprise that these were issues that the Inquiry was interested in. Witness statements failed to deal with or inadequately addressed gaps in data acquisition and analysis, with witnesses appearing to only appreciate that these aspects of the response had been deficient on questioning from the Inquiry. This was particularly the case with issues of equality, with the former Minister for Health suggesting that, on equalities, "*coming out from even this morning's evidence sessions and from previous evidence sessions, there may be a query that it needs to do more.*" **[33/88/5-15]** The evidence, and the manner in which it emerged, strongly points to an absence of reflection on and understanding of these failings and their significance in advance of the hearings.

(iv) Concerns relating to DNACPR, including whether what was happening in practice matched policies and law, and whether improvements in practice are required to safeguard vulnerable individuals were, again, not addressed comprehensively in witness statements. The conclusion that these issues had not been the focus of informed consideration, even now, was reinforced by answers given in oral evidence. The former Minister for Health focused in evidence on emphasising that that there was no formal policy of imposing blanket DNACPRs. As will be apparent below, that response failed to take onboard the range, extent and significance of the concerns raised, and therefore missed the point.

(v) The Chief Executive of the NI PHA found time in his relatively short witness statement to mention "Operation Clean Up", an exercise both minor (cleaning desks in the PHA Belfast office), and simultaneously demonstrating a lack of understanding that the evidence now (and arguably at the time of this "Operation") suggested that the virus was airborne, and the exercise had therefore been of little benefit to preventing transmission. This misplaced focus put starkly into context

the acceptance, in oral evidence, that the PHA statement lacked reflection on the wider decisions taken by the Agency. Whilst an objectively minor complaint, the juxtaposition resonates, by simultaneously demonstrating the failure of the PHA to understand the development in scientific consensus during the course of the pandemic and the failure of the PHA post pandemic to reflect on the significant missed opportunities and points of learning.

(vi) In the same vein, when asked about lessons learned from the pandemic, the NI CMO initially answered to identify only examples of good practice, and only when pushed identified lessons learned from what had not been positive aspects of the response **[10/158/16 – 10/161/9]**.

194. The Inquiry may recall in that, in our written opening for M2C (dated 19th April 2024) NICBFFJ raised concerns about an absence of self-reflection and the failure of NI evidence to engage in the significant debates about the pandemic. In that opening, in relation to "the lost month of February", we noted:

"*It is not at all clear from the witness statements in this Module that there is any appreciation from the main witnesses involved, that the NI response was flawed…*" [19]

195. Similarly, at the close of M2C we identified two significant concerns with the evidence before that module:

"(i) The self-justifying approach of a number of witnesses who sought to avoid responsibility or blame; and

(ii) The lack of self-reflection on the part of those in key positions, who appear not to acknowledge or accept those errors which did occur."

196. Against that background, the lack of any readiness to reflect and willingness to learn in this Module is all the more disappointing. This attitude emanating from NI is in itself flawed as:

(i) It reinforces the conclusion that the healthcare response to Covid was not properly informed and managed, and was therefore hindered at a fundamental level;

(ii) It ensures that lessons have not and been learned, and, absent a volte-face, will not be learned;

(iii) It hinders the Inquiry in identifying what went wrong and how to remedy it in future;

(iv) It leaves little room for confidence that any recommendations made by the Inquiry will be properly implemented.

197. We suggest that the Inquiry comments on the lack of self-reflection on the part of key NI actors as a distinct concern in the M3 report, and makes recommendations to ensure

that informed self-reflection, and where necessary investigation, should form part of any future pandemic response.

198. We will highlight some examples of the lack of reflection in the various issues addressed below. Before addressing these issues, the starting point for considering the NI healthcare response must be to consider the dire state of the NI healthcare system when the pandemic hit.

NI healthcare system overwhelmed pre-pandemic

199. There has been some debate in this Module about whether it is fair to say that the UK healthcare system was not overwhelmed in this pandemic. As noted above, former UK Secretary of State for Health, Matt Hancock, insisted that whilst some parts may have been overwhelmed for short periods, and standard of care may have dropped due to staff being stretched more widely than usual, the NHS was not overwhelmed. He defined that term as meaning:
"That people wouldn't be able to get any treatment at all in hospitals; that there would be the inability to give the basic level of care that people needed. When I said that we needed to stop the NHS being overwhelmed and I set that as an objective, what I meant was that people in this country have a right to healthcare from the -- provided free at the point ofc delivery according to need, not ability to pay."

200. As our submissions at Section Two above make clear, we do not agree either that the UK Healthcare system was not overwhelmed during the pandemic, or that what occurred did in fact meet Mr Hancock's definition. What appears to be less controversial is the view that the state of the NI Healthcare system was effectively overwhelmed prior to and irrespective of the pandemic. The strength of the acknowledgements at the poor state of the healthcare system, combined with the seniority and experience of the witnesses giving evidence, bear consideration.

201. The NI CMO, when asked whether the population of Northern Ireland have "*the healthcare service that they needed at the start of the pandemic?*" answered simply "*No.*" When asked whether the then HSC was equipped to meet the needs of the Northern Ireland population at the start of 2020, he said:
"*A. No, I don't believe it was, and I think that that's demonstrated by the problems that the population was experiencing with access to care, and the frustrations that those providing that care had been – experienced for many, many years. … I think that many health professionals, those working in the service, the leadership in the service were increasingly*

becoming demoralised at the gap between the need and our capacity to deliver that." (**10/36/23- 10/37/1; 10/38/2-14**)

202. When this evidence was put to the former Minister for Health, Robin Swann, he confirmed "*I would fully agree …*" **(33/1/20 – 33/2/5)**

203. This appears to meet Mr Hancock's definition of an inability to deliver the basic level of care that people need.

204. The view of both the Minister and NI CMO also appeared to be well supported by the various statistics and evidence. The evidence from the NI CMO included:

(i) In England at the end of November 2019, there were 1,398 people waiting more than 52 weeks on the pathway to start treatment whereas in Northern Ireland, population 1.9 million, there were over 100,000 people waiting for more than 52 weeks for the first outpatient appointment (that is, over 5% of the population), a figure 2,000 times worse than the figure in England (per head of population) **(10/41/2-10)**.

(ii) "Prior to the pandemic, waiting times for elective care were the worst in the UK and among the worst in Europe." (**10/39/4-6)**

205. Minister Swann's evidence was that:

(i) "*We didn't have enough staff actually to deliver the healthcare service that we wanted to, even pre-pandemic*" **(33/7/21-24)**

(i) We were challenged with the number of healthcare staff that was available but also our structures were -- across the healthcare estate, were ageing and needing updating and investing **(33/6/19-22)**

(ii) NI had the longest waiting lists across the UK (**33/4/13-14**)

(iii) The "*pressures on our ambulance service in NI are not specific due to the Covid Inquiry. In fact, there's still a challenge in regards to what were able to deliver and, again, against what we want to deliver…*" **(33/108/17-21)**

(iv) There had been no paediatric pathologist in the jurisdiction since 2019, the Minister noting that the challenges resulting from this *"are the outworkings of stories like Ziggy's*". [33/131/16-23] (the Inquiry will no doubt recognise the reference to the tragic death of Catherine Todd's newborn baby Ziggy, to which we return below).

206. The Elective Care Framework report from June 2021, noted:

"*Waiting times are currently so long in Northern Ireland that Emergency Departments ... and other urgent pathways have increasingly become the default entry point for patients requiring treatment,* ***either due to patients waiting so long that their condition***

***becomes urgent**, or because EDs are seen as a faster way of accessing diagnosis and treatment. Fixing waiting times will therefore also help take some of the pressure away from EDs.*" (emphasis added in bold)

207. Failing to provide medical care until a patient deteriorates so significantly that their condition becomes urgent and, as a direct result, requires the hospital admission via the emergency department is symptomatic of a healthcare system that is broken, and was so prior to the pandemic.

208. None of this is to excuse the errors in the healthcare response, or to permit a fatalistic approach to assessing that response. The evidence supports a conclusion that errors as part of the NI healthcare response did in fact have detrimental consequences and lead to worse outcomes, including increased deaths. Unquestionably, one of the primary underlying causes of these issues is a lack of adequate, secure and long term funding and investment. In previous modules, the Inquiry has heard evidence of recurring single year budgets and an absence of long-term investment. Whilst the Inquiry may be hesitant to make recommendations that services receive a specific level of funding, one aspect of learning lessons and preventing recurrence is ensuring accountability. The Inquiry should therefore make very clear that the NI healthcare system was failing those in the jurisdiction in advance of the pandemic, that this was primarily due to political decision-making as well as political dysfunction, and that this set the scene for the healthcare response.

Droplet definition and near field or far field transmission

209. One of the most-high profile and controversial debates within this module was in relation to whether there was near-field or far-field transmission of the virus, including when this should have been appreciated by those drafting and implementing IPC guidance. Related to this were debates about whether transmission was due to particles which behaved ballistically, or particles which were aerosolised, as well as differing views on the properties of those particles which behaved ballistically (primarily size, but also the extent to which they carried infectious particles). There are two broad interrelated points to make in relation to this which arise from the evidence, and which apply irrespective of the substantive conclusions on this issue.

(i) No significant NI witness appears to have engaged in substantive reflection on how the NI healthcare system understood and responded to this issue, whether the approach was wrong and why, and what lessons can be learned.

(ii) Where evidence was given by NI actors on this issue, their view appeared to be that they had simply followed the approach taken by the UK IPC Cell, and/or that the UKHSA applied in England, and that this was appropriate. There was

an inexplicable lack of consideration about whether that response had been flawed or otherwise; it was simply asserted that NI lacked sufficient expertise to diverge from the approach taken in England, and that would continue to be the case in any future pandemic. By circular logic, this was apparently one reason for the lack of self-reflection.

210. The lack of consideration from actors in NI on this issue, even now, is apparent from the fact that statements from key NI actors were silent on it and the implications it held for the healthcare response. When asked, the NI CMO admitted he did not have a view on the controversy, but "*accepted the advice that he was provided*", meaning advice from NHS England/UKHSA.

211. The Minister for Health accepted that he had been aware of a disagreement among scientists about the primary route of transmission, i.e. droplet or aerosol, in May 2020, but was strikingly lacking in detail, noting he didn't recall "*the specifics*" but, described it as one of the "*general conversations that were had with CMO and CSA in regards to different aspects of the pandemic*" **[33/152/25- 33/154/4]**. This lack of recall about such a central issue, even now, suggests it was and is not seen as particularly significant. That in itself suggests a lack of appreciation for the importance of these issues.

212. At times however evidence of the lack of understanding about modes of transmission went beyond mere silence, and resulted in positive statements that served to demonstrate an apparent failure to comprehend that this was an issue of controversy at all, let alone that the apparently consensus view now is that:

(i) There was far field transmission, most particularly in indoor locations lacking adequate ventilation where individuals spent significant amounts of time;

(ii) That this description matched a description many of NI's ageing hospitals;

(iii) That this was due to smaller respiratory particles which evidence suggested that FRSM masks provided inadequate protection in contrast with FFP3's;

(iv) That the risk from "aerosol generating procedures" ("AGPs") was not greater, and in some cases was less significant than, the risk from respiratory particles exhaled through breathing or talking.

213. By way of example, Aidan Dawson, Chief Executive of the PHA, gave evidence that they had to deal with concerns on the part of healthcare staff that they were being provided with inadequate PPE. He gave the example of the use of FFP3, and noted:
"the guidance was, you should use them only when you're in -- or used in AGP, aerosol-generated procedures, etc, people might have thought, well, actually I should be using that if I'm working in an ED department or not involved in non-aerosol-generated. So I think

there was always that concern. I think people were genuinely frightened and sort of always sought to have a higher level of protection than was sometimes what was being recommended within the guidance."

214. When asked what was done to assuage such fears, he described the response being "*look, this is the best evidence we can have confidence in at this point in time and we had nothing to dissuade to us move away from it.*" He nevertheless confirmed that these fears "*never went away*", and, tellingly, speculated that this was "*was because people just had a high degree of anxiety at that point in time and whether or not you could have ever dissuaded it in terms of that, I don't know.*" (05/11/24, 81, 2 – 82, 11).

215. Strikingly absent from that evidence was any apparent comprehension that there is significant debate among experts over whether the IPC Cell got it wrong, or any acknowledgement of the evidence of the Inquiry's expert, Professor Beggs, who identified that: "*physical science suggests that many so-called AGPs actually produce fewer aerosols than normal activities such as coughing.*" (11/09/24, p. 123 L1-3) There was therefore "*overconcentration on AGPs and the role they play to the detriment of us just talking and breathing…"* (**11/09/24, 123,22-23**).

216. If Mr Dawson was expressly taking a side in this debate, underpinned by scientific evidence and logical conclusions, then his view that PPE provision was always correct, and that anxiety on the part of healthcare workers was simply an example of irrational anxiety in a pandemic, could be understandable. However, his evidence suggests he was entirely unaware:

(i) That this was even an issue of controversy at all;

(ii) That evidence now suggests there was very good reason many healthcare workers would have to question the focus on AGPs, as the Inquiry's own instructed expert has done.

217. Instead, Mr Dawson's suggestion that HCWs may not be capable of being reasoned with in such circumstances was not only patronising, but demonstrated a lack of knowledge and understanding about some of the most fundamental and controversial issues relating to the healthcare response.

218. We consider that this is a significant problem for a number of reasons. Firstly, to the extent that NI did have a voice in making IPC guidance, it was through a representative of the NI PHA who attended the UK IPC Cell. Whilst the evidence suggests that they were significantly outnumbered by those attending from NHSE, and the meetings were frequently dominated by public health officials from Scotland, the fact that the NI PHA's

evidence fails to *even acknowledge* that there is a debate suggests that NI lacked informed input into a high consequence issue for NI the healthcare response.

219. Relatedly, this prevented NI authorities from meaningfully engaging with those who had legitimate and educated concerns about the approach to transmission, including the manner in it was informing aspects the IPC response up to and including IPC Guidance. By way of example, GAPA (the predecessor of CATA) wrote to the UK CMOs on 12 March 2021 to raise concerns at the approach to airborne transmission, and to seek a review of PPE and ventilation guidelines consistent with airborne transmission of Covid-19 (INQ000114297). The approach of the NI CMO was, in general, that we simply followed English guidance, and there was not much which could be done about that in the future. Therefore, regardless of concerns raised from credible and informed sources, NI decision-makers have simply delegated their discretion to decision-makers in England.

220. The lack of democratic accountability in this approach is of fundamental concern. With no individual or entity in NI taking responsibility decision making on an issue of critical importance, there follows an absence of accountability for errors. This is particularly significant on an issue such as this, where the errors were far reaching. Aside from this approach being questionable constitutionally in circumstances where health is a devolved issue, there are two practical consequences.

221. Firstly, a lack of such accountability also often results in poorer decision-making, as was evident from the evidence in this Module. One of the concerns identified by NICBFFJ, emanating from UK IPC Cell minutes is that, when a change in the guidance was proposed in December 2020, the NI representative in that meeting raised a concern that a change of position might lead colleagues to "*think that they had not been appropriately protected with what has been previously recommended*." (INQ000398242) We consider that this was an inherently inappropriate, self-serving factor to take into account when assessing the merits of a change in IPC Guidance. The lack of accountability for IPC Guidance no doubt contributed to this approach.

222. A second problem with a lack of accountability is that there is no incentive to consider where things have gone wrong and to take steps to correct them. That this occurred in practice in NI is glaringly apparent from the evidence. The CMO's evidence was that there was no realistic option but to follow UKHSA guidance. The evidence of the former Minister for Health was that he would have expected the PHA to raise any concerns about the guidance from the UK IPC Cell, and would have expected it to reach him via the PHA, the CSA or CSO, albeit this had not happened in practice **[33/154/16-23]**. He did not demur from the CMO's evidence that NI was reliant on (or, we suggest, content to adopt) the

approach of the UKHSA. At best, in order to avoid a recurrence in future, he pointed to the fact that the First Minister and Deputy First Minister had not employed their own CSA, and that this may, somehow, assist **[33/156/9-11]**. We observe that, at present, it is difficult to see how that would assist in circumstances where the DOH was the lead department for the pandemic response, and the healthcare response in particular.

223. The lack of reflection on these issues clearly hinders the ability to make recommendations to ensure there is no repetition of errors in future. Nonetheless, we consider that the Inquiry should make findings and recommendations on this issue, which we have included in the recommendations section below. We also invite the Inquiry to find that the failure if any NI entity or individual to accept responsibility for IPC Guidance was a flaw in the healthcare response, as it undermined the prospect of accountability.

Nosocomial Infection

224. Determining the mode of transmission is the starting point for identifying how to protect against transmission, which is itself essential in order to take informed steps to reduce nosocomial infection. Prof Beggs, the Inquiry's instructed IPC expert (physical sciences), described the droplet assumption as a *"house of cards, everything rests on that."* (**3/118/3-13**); Prof Barry Jones of CATA described this issue as "*absolutely critical and the elephant in the room*." (**4/3/19**). It was critical precisely because infection control measures which operate against near field transmission may not operate against far field transmission, and vice versa. Prof Beggs notes, for example, that where a disease is classified as being airborne, and spread via aerosols, then these can be flushed away by ventilation air and "*providing adequate room ventilation becomes an important issue.*" In contrast, "*if a disease is classified as droplet borne… the room ventilation rate will have no effect in its transmission.*" The importance of this issue for managing nosocomial infection is therefore self-evident.

225. This is also apparent from examples of the product of the Nosocomial Support Cell in NI. The Inquiry has heard evidence of "*severe and sustained nosocomial outbreaks affective both patients and staff in a number of wards and departments throughout the [Southern Health and Social Care] Trust.*" **[INQ000417483/2§1.1]** The Nosocomial Support Cell compiled a report on an initial visit to Craigavon Area Hospital on 22nd December 2020. Whilst ventilation is referenced in the report (apparently because it was an issue raised by hospital IPC staff), the Cell did not mention the importance of ventilation at all in their report, nor the difficulties faced in ensuring adequate ventilation to prevent far-field transmission, notwithstanding including a section in their report on "Environmental Issues." Instead, the focus was on social distancing and, to a lesser extent, safeguards

around aerosol generating procedures. **[INQ000417483/4§3.1. See also the entirety of the report]**. That suggests that the Nosocomial Cell was still operating on the basis that transmission was near field and not far field.

226. In contrast, the Report of their visit in January 2021 does focus more on ventilation, including a sub-heading highlighting the issue **[INQ000417484/3§2.8-2.9]** This section acknowledged that the wards relied on opening windows for ventilation, and "*in many instances the recommended air change rate of 6ac/hr cannot be achieved.*" **[§2.9]** After commending staff for good IPC practice, the report concluded:
"*It is difficult to see what more the Trust can do with the physical environment given the constraints of the existing layout/fabric. This coupled with the fact that it is a busy live acute site with little opportunity to decant to other areas makes any large-scale refurbishment difficult in the current times. The Trust has a Masterplan for the redevelopment of the whole site, but this is a very significant development that will require considerable capital investment and most probably a programme that will extent over several decades.*" **[§4.12]**

227. The Cell's recommendations were therefore that "*the Trust should develop short term estate solutions and urgently seek DoH funding to implement them.*" **[§5.1a]** Aside from short term solutions to increase capacity or improving areas in wards, the cell could only recommend that *"the Department of Health should urgently consider the Trust's Masterplan for redevelopment*", requiring considerable capital investment and a programme that would extend over decades. **[§5.1g]**

228. The comparison between the two reports serves to demonstrate the very real difference that changing conclusions on the routes of transmission pose for identifying the correct measures to prevent nosocomial infection. This issue goes way beyond mask specification. and is fundamental for the response to nosocomial infection.

229. That being the case, one method for assessing whether measures imposed to prevent nosocomial infection were in fact effective, would be to review those measures and determine the extent to which they were working, identifying both poorly performing cases, but perhaps more significantly, considering better performing hospitals and seeking to understand why that was so.

230. In contrast to the Nosocomial Support Cell's report on Craigavon Area Hospital in January 2021, the benefits of the opportunities for ventilation from modern hospital estate were apparent from the evidence of Catherine McDonnell, Chief Executive of WHSCT. She identified that Altnagelvin Hospital had a comparatively better record for nosocomial infection during the pandemic, which she considered was at least partly due to aspects of

their own response that went beyond or were not aligned with public health guidance (including testing healthcare workers who would have been regarded as asymptomatic), as well as the fact that new hospital buildings allowed a greater focus on increasing ventilation. [**13/183 12 – 13/186/16**].

231. These examples suggest that there were opportunities to learn lessons from what occurred in practice. However, Aidan Dawson of the PHA was asked whether the PHA engaged in any tracking of whether IPC Guidance was effective, and confirmed:
"A. I think there was an assumption the IPC guidance was out there, it was being adhered to and the general sort of tracking of the disease was not sort of significantly different from other parts. But I can see the point you're making, was it specifically tracked on whether or not the IPC guidance was effective, I don't think it was, don't believe it was."

232. The contrast in the evidence from both Craigavon, where IPC Guidance was followed, but little could be done due to an aged hospital estate and consequent difficulties with ventilation, and Altnagelvin, where there was a comparatively better outcome for nosocomial infection, apparently due to greater capacity to ensure adequate ventilation, suggests, anecdotally at least, that tracking whether IPC Guidance was effective in limiting nosocomial infection had the potential to identify these issues at an earlier stage.

233. We would also note that the reaction to these examples again suggest that little heed was paid to the work of the Nosocomial Support Cell. Minister Swann in his statement, in addressing issues of nosocomial infection, identified the creation of the Nosocomial Support Cell, as one aspect of the steps taken to address challenges arising from Covid-19 infections in healthcare settings (§233). He specifically references the Cell's inspection of Craigavon Area Hospital and observed that "*these reports were a timely source of feedback to Health and Social Care Trusts on the approach and systems operating in their respective hospitals to address and mitigate the impact of Covid-19 as it emerged in the acute hospital sector*." However, it is difficult to identify:

a. Firstly, any evidence that the NSC's 'timely feedback' was meaningfully considered by the Department and changes implemented as a result; and
b. Secondly how this recommendation, or the report and recommendations in general, could have been considered "helpful", save to the extent that it identified that effective measures to prevent or limit Covid 19 could not be implemented in Craigavon Area Hospital until a new hospital was built.

234. Not mentioned in the Nosocomial Support Cell's report on Craigavon was the fact that technologies exist which could supplement ventilation and could therefore provide an interim measure pending the decades long project of developing new hospital estate for

Craigavon. These measures, including portable air cleaners, upper room UV lamps, and far UVC lamps, were considered in detail by Prof Beggs **[INQ000474276/97§267 onwards]** (to whom the Inquiry's IPC experts (on the challenges of protecting everyone in healthcare settings from Covid-19) defer to on this issue see **[INQ000474282/95§9.52]**). Prof Beggs concluded:

"*280. Collectively, the evidence presented above suggests that supplementary air cleaning devices have the potential to reduce the airborne viral load in hospital wards, and potentially mitigate the transmission of SARS-CoV-2 infection. However, while this is encouraging, much remains unknown about how such devices should be deployed in healthcare facilities to best effect.*"

235. Given the static nature of hospital estate, and the inability to quickly change or upgrade this at short notice, or even in the medium term, further investigation of the benefits of such technologies would appear prudent and necessary.

236. We have therefore made proposed recommendations in the corresponding section below. It will be apparent that this final proposed recommendation on this issue involves seeking more information. One reason for that is that an effective response is most likely an informed one. That is why the wide range of gaps in data in NI when responding to the pandemic are particularly problematic.

Data and equality

237. One recurring theme of this Module's evidence has been the limits on information and in particular data collected in NI. This included:

(i) Whilst deaths among health service staff from Covid were reported to the DoH, the information was not collated by the Department [**10/78/14-21**]

(ii) There was a lack of information available about the ethnicity of the healthcare workforce, which also hindered risk assessments, including the risk of loss of staff numbers to illness or shielding, and any additional measures that may be required to address those risks **[33/64/24-33/65/21**; **33/67/2-22**]

(iii) The NI CMO became aware in April 2020 that there was a disproportionate impact of Covid-19 on black and minority ethnic workers in particular, but it was not possible to consider how that impacted in NI due to a lack of data on the issue - a state of affairs which remains in place today **[10/85/7-17; 10/87/14-21]**

(iv) When asked why ethnic group data or disability data was not kept by the PHA when recording COVID deaths, the Chief Executive of the PHA accepted "*we had very poor data on both disability and ethnicity in Northern Ireland.*" [**26/73/19-20**]

(v) Despite being aware of concerns about fit-testing of FFP3 masks, which raised equalities concerns, including for women with smaller faces, equalities issues were not considered as part of the Department's review of PPE **[33/87/16 – 33/88/15]**

(vi) The NI PHA had been provided with a template spreadsheet to complete with data by Public Health England, and had simply failed to obtain or input the data on staff illnesses and deaths, leaving those rows blank [**26/75/18 – 26/77/05**].

(vii) The DoH did not routinely collect data in relation to the number of people referred to mental health services. When asked how it was possible to effectively commission mental health services without knowing how many people needed such services, the Minister accepted *"a weakness in the system*" [**33/121/1-21]**;

(viii) The PHA considered that their response to the pandemic was hindered at the outset of the pandemic because the lacked the necessary level of primary care and critical care data that they required as a significant aspect of responding to infectious disease **[26/61/8-26/62/7]**. (In response, it appears to be the position of the DoH that such data was available but the PHA may have been unaware [**39/156/1-39/157/6]**. The extent to which the DoH position is based on evidence placed before the inquiry is not clear. Nor is it clear why they did not put this to Mr Dawson during his evidence and allow him an opportunity to comment).

238. We have identified above that inequalities were, generally, not prioritised as part of the UK Covid response. The situation in NI appears to have been worse. The failure to have a system to collect and analyse data, to allow informed conclusions to be reached and effective decisions to be taken, suggests not so much that these issues were not prioritised during the pandemic but that they had been long ignored. There were clear risks for minorities, for the disabled, for healthcare workers, but evidence was simply not collated in a way that would allow an informed risk assessment or response to those risks.

239. The Inquiry has been told in evidence that many of these failings will now be resolved by a new system, Encompass, because it should be possible to quickly identify what data is held, and that data will be held centrally in one system [**33/70/23-24**]. To a considerable extent, and in the absence of detailed evidence, the Inquiry will have to take the Department at its word, although we note that the timeframe for the rollout of this system was 10 years, and it is as yet only 60% implemented.

240. However, even if Encompass does address many of the data gaps identified, that does not mean the Inquiry should shy away from findings and recommendations on this issue.

241. We again consider that identifying this as a failing provides a level of accountability in itself. The failure to collect much of this data amounted to a flaw. The failure to ensure data

related to equalities, and specifically that captures and identifies inequalities, should be regarded as particularly egregious.

242. It is also the case that the issue has not been resolved simply because the data gaps identified have been filled. Different data may be required in a future pandemic.

PPE

243. The evidence of the Chief Executive of the PHA was that during the pandemic, NI HSC did not experience any shortage of PPE stocks therefore there was no need identified to reuse PPE. In his oral evidence he doubled down on those assertions, indicating that he had been advised by his staff that there had not been a single report to the PHA of staff not having access to the necessary PPE. **[26/83/1-25]**.

244. The question of whether this was because PPE requirements had been identified to ensure they could be met, particularly in relation to the preference for FRSMs over FFP3s, has been addressed above. It is notable that this is not merely a concern of NICBFFJ, but was also the evidence of Dr Catherine McDonnell, former Medical Director of WHSCT, [**13/169/14 –13/170/8**] Her statement was put to her: *"The biggest challenge to implementing IPC Guidance was concern in the early stages of the pandemic that guidance was being developed around supply issues rather than safety and that safety measures being advised were inadequate*". She agreed, though developed that by adding in her oral evidence "*The IPC protection or PPE protection was particularly for people who were in COVID areas but it wasn't really being prescribed for people who sat outside those Covid areas. So the concern for a lot of nurses and doctors were that with the limited knowledge that there was of how Covid represented, that they too should have had that protection and, thankfully, fairly quickly that did happen. But there was a sense that normally when you suspect that there might be a risk that you would use personal protective equipment and that wasn't possible at the start because of lack of availability.*"

245. The evidence of Mr Dawson was not consistent with the evidence of Prof Banfield, who clearly considered that the problems with PPE were not limited to Great Britain. He describes "*acute shortages*" throughout the UK, quoting UK-wide COVID Tracker surveys. He also quotes a GP Contractor/principal in NI who said "*amazed at how paltry it was. I felt undervalued. like going over the top in WW1 with a bow and arrow*" and an NI consultant saying there was "*haphazard availability, multiple fit-testing due to masks going out of stock.*" **(INQ000477304_0138-0139§§325, 326)**

246. It was also inconsistent with correspondence sent by Pat Cullen Director at Royal College Of Nursing to the Chief Executive of the Health and Safety Executive Northern Ireland on the 31st March 2020 stating expressly that "*We are receiving increasing reports of a lack and adequacy of PPE available to frontline nursing staff, not just in hospitals, but in GP surgeries, nursing homes and for community nurses visiting people in their homes. Our members tell us that they simply cannot obtain enough equipment and some of the equipment that is distributed is not sufficient to meet their clinical requirements*" **(INQ000400948)**

247. One possible explanation for Mr Dawson's misplaced confidence was the fact that there was an absence of central co-ordination of PPE stock with each Trust, Hospital and potentially each ward managing its own supply and, additionally, there was no specific mechanism for Trusts to report back to the Department re the level of PPE and distribution to facilities **[cf evidence of Robin Swann at 33/142/1-25]**. The height of the mechanisms established appears to have been the creation of a single email address, which allowed an opportunity for frontline staff to email the Trust or the Department if there are problems. Aside from being inadequate, the obvious flaw in this approach is that mechanisms should have been established to prevent problems arising, not merely to ensure they were reported by after they arose. This meant that by 3 April 2020, the DOH were still asking CEO's to fill in returns on PPE in the absence of a direct mechanism of communication with the DOH **[33/144/1-19]**.

248. The evidence of medical professionals, and of their representative organisation, is that PPE was frequently inadequate and/or insufficient. That is not reflected in the evidence before the Inquiry from, for example, the NI PHA and the DoH. It appears too little attention paid to what the situation on the ground was, including by establishing effective mechanisms to ensure timely information flow before problems developed. This supports a conclusion that the approach was systemically flawed, and we consider that the Inquiry should say so.

DNACPR

249. The issues in relation to DNACPR have long been identified as one of the key concerns on behalf of NICBFFJ. Family members and others raised concerns during the pandemic and have consistently raised it since. Their concerns find support in the public statement that the BMA (with others) felt compelled to issue on 1st April 2020, within just one week of lockdown being imposed It was therefore extremely disappointing for those we represent to hear evidence of individual and institutional inertia in response to these concerns from an NI perspective. [INQ000477304/152/372]

250. When asked why there was no NI equivalent to the CQC review into the use of DNACPR conducted in England, Minister Swann stated firstly that he "believed" that the CQC investigation "*actually covered Northern Ireland as well in regards to some of their responses.*" When pushed on this he appeared to double down, explaining the lack of in-depth assessment in NI as being because "*there was a reliance on the work that had been done by the CQC.*" **[33/94/15 – 33/95/2]**. Given his purported reliance on the work of the CQC to justify the absence of an NI review into DNACPR, it is a matter of particular concern that in his evidence he suggested that he first understood that the CQC report covered NI from his reading in preparation for his evidence to this module **[33/147/25 – 33/148/11]**.

251. We consider this evidence to be wholly unsatisfactory. It is not at all clear why the Minister considered the CQC report "covered" NI. His answers to this question lacked specifics. The CQC listed participating stakeholders in the Appendix of their interim report, and set out "How we carried out our review" in Appendix A of their final report, including expert Advisory Group Members **[INQ000235492/44-47]**. There is no mention of NI. Whilst the list includes some organisations which are UK wide, no NI organisations are included. The report was conducted under legislation which did not apply in NI (The Health and Social Care Act 2008), and which goes out of its way to emphasise that the powers relate to investigating healthcare or social services provision in England (see s. 48(2) of the Act). Therefore, even if some UK wide organisations tangentially touched upon NI issues, there is no reasonable basis to suggest that the CQC "covered" NI.

252. It is also difficult to see how there could be anything described as "reliance" on the CQC report in NI. That is because the repeated refrain, when asked about DNACPR, is that there was no blanket policy of DNACPR imposed. This was the answer given by the Minister during the pandemic, it was the answer given by Mr Swann in evidence and it was also advanced in the Department's closing oral submissions in this Module. That answer serves to demonstrate that, contrary to the assertions that the Department "had listened" to the concerns and evidence, it appeared the message has still not gotten through. By way of example, the CQC report made 11 recommendations under 3 broad headings, and identified the responsible department for implementing each recommendation (we noted in passing that no NI entity was identified as a responsible entity). The recommendations went well beyond issues of ensuring Guidance was lawful, but included recommendations on ensuring health and care professionals have not only the knowledge to make ethical decisions, but also the skills necessary to have difficult conversations about this issue in an appropriate manner. The report included recommendations about providing support for people and their families, so that they all share the same understanding of DNACPR

decisions. Particularly significantly for those we represent, it included recommendations to ensure improved oversight and assurance.

253. In the Minister's statement (INQ000492281/99§§306-307) he identified some work around ethical advice and guidance provided to clinicians but there is no mention of the majority of the issues raised in the CQC's recommendations. That reinforces the conclusion that there was no significant reliance placed on the CQC's report by the NI DOH.

254. The Minister was also apparently misdirected when focusing solely on what the guidance contained and whether this permitted blanket DNACPR decisions. There are two reasons for this. Firstly, the concerns raised were wider than this issue. This was so well known that even the Chair interrupted the NI CMO's evidence on the issue to identify:
""*Ever since I've been appointed Chair of this Inquiry, Professor, I've had complaints from bereaved family members that notices were issued when the patient wasn't able to give their consent, when there had been no consultation with the family, and also -- and I don't know if this is a concern that has come to you – that do not resuscitate notices, I'll call them shorthand, were treated as do not treat notices.*" **[10/133/20-10/134/2]**

255. Even if the concerns raised had not been wider than the issue focused on by the former Minister, his answer, in focusing primarily on what the policy stated, would still have been insufficient to allay concerns. Prof Summers and Dr Suntharalingam confirmed what ought to have been uncontroversial: that it is important to consider not only what the general policy is, but also to acknowledge what occurred in practice (**INQ000474255/51§123**). The fact that NI did not see a similar investigation to the CQC report has meant that it is extremely difficult to identify with certainty what happened in many DNACPR cases during the pandemic. That is a problem, the NICBFFJ evidence to this module includes examples of what happened in practice, including cases of communication being inappropriate and of a shockingly poor standard, and examples of a DNACPR being imposed on individuals, purportedly with their consent, at a point in time when their family considered that they would have been unable to provide informed consent.

256. It is not only NICBFFJ who consider these allegations should have been particularly concerning for the Department. When asked whether one of his answers was tended to suggest that there were cases where guidance was not followed as it should have been, the NI CMO stated:
"I personally don't know of circumstances where that's the case. My concern is that there were circumstances where that may have been the case. And my concern furthermore is you now have bereaved families who have a level of distrust in terms of decisions were

made, why those decisions were made, by whom those decisions were made, and that -- that is deeply concerning." [**10/133/3-16**]

257. The Chair will recall the evidence of Mr Swann that he was presently "not sure" whether the Department had conducted an investigation into the concerns raised about DNACPR, and further that he considered there was now "*an opportunity actually to retrospectively do that…*" **[33/149/22-33/150/7].** The combined evidence of the former Minister of Health and the NI CMO suggests that there is not only an opportunity but a need to retrospectively consider the true picture, not least to address the 'level of distrust' that now lingers amongst many in our society. That the DOH, in its closing oral submissions on this issue appeared to consciously distance itself from the concessions offered by its witness, former Minister Swann, yet again tells a story of institutional defensiveness and lessons that will not, willingly, be learned.

258. Former Minister Swann is no longer in post. NICBFFJ hope the new Minister will have taken onboard his comments emphasising the importance of conducting such an investigation at this stage.

End of life care

259. It is important to note that the concerns about end of life care on the part of NICBFFJ members are not limited to abuse or misuse of DNACPR notices. Similar systemic concerns have been raised about other decisions on end of life care, including concerns at apparently following of the discredited Liverpool Pathway, as well as the use of the "syringe driver" or particular drugs to effectively hasten death.

260. For the same reasons as identified in relation to DNACPR, it is clear that simply looking at what policies and guidance was formally in place is insufficient, there should be some scrutiny of what happened in practice. As a result, any investigation in relation to DNACPR should include all end of life decisions.

Testing

261. We addressed failures of testing in detail in submissions in M2 and M2c (See for example, NICBFFJ closing submissions for M2C at [53]-[58]). We do not intend to rehearse those submissions given space constraints. The Inquiry will recall the evidence in M2 and M2c of the lost month of February, and how the information that testing was one of the few effective responses to the pandemic, but that those in authority, including the PHA and DOJ acted too late.

262. We note that the Chief Executive of the PHA accepted in oral evidence during this Module that there had been a failure on the part of the PHA to identify the importance of widespread testing of healthcare workers and patients in various settings, and further accepted that the Guidance on testing, produced on 19 March 2020 (which ran to only three pages) was inadequate and suggestive of last-minute scrambling to produce such guidance. We consider those answers were accurate and should be accepted by the Inquiry. **[26/105/12-24]**

263. Despite this, in its closing submissions to this Module, the Department apparently took issue with Mr Dawson's evidence, and asserted that they did not at any stage "*fail to recognise the importance of widespread testing*" but noted that at the early stages of the pandemic, "*there was a lack of testing capacity*". In addition to the absence of meaningful reflection, there are significant problems with those assertions:

(i) Whilst recognising that these were closing submissions, and therefore limited by space and time, no evidence was provided to support that positive assertion;

(ii) The evidence of M2C, and the issues surrounding the lost month of February, identified that there was a failure to appreciate the importance of testing, and therefore to increase the necessary capacity, at an early stage.

(iii) The evidence in M2C was that the Department had suspended test and trace in early March, at the same time as in England, but notably after only 13 positive tests and before testing capacity had been reached. The justification for this appeared to be that they were following the approach in England. It is difficult to interpret that decision in any way other than one which failed to recognise the importance of widespread testing. It certainly was not a decision which was mandated by a lack of testing capacity, as that capacity had not yet been reached.

(iv) When the executive eventually was informed that test and trace had been suspended, on 16th March, handwritten notes record the Minister as saying he would prefer to "*focus resources on combatting Covid 19 rather than counting*" **[INQ000226010/2]**. That comment again suggested the Minister, and those advising him, failed to recognise the importance of widespread testing.

264. The conclusion that the value of testing was properly appreciated by the DOH was further undermined by the evidence of Dr McDonnell, who identified that one reason contributing to the lower nosocomial infection in Altnagelvin hospital was that they had tested healthcare workers who were not regarded as being symptomatic under the guidance then in place, and as a result were able to identify staff members who were Covid positive and potentially infectious, and who, had it not been for the hospital's departure from the guidance then in place, would have continued working and thereby risked

infecting others **[13/183/12-13/186/16]**. That suggested that the guidance in place failed to recognise the potential significance of testing for preventing nosocomial infection.

265. The Inquiry should therefore reject any suggestion that the DOH had in fact recognised the importance of widespread testing at an early stage, but failed to ensure it took place due to limited capacity. To the extent that this did occur, it was too little too late.

266. We appreciate that the inquiry proposes to consider in detail the issue of testing in Module 7, and we propose to return to this issue at that point. We note however that testing held significant potential for reducing the levels of isolation of those in healthcare facilities, so it is to this issue we now turn.

Isolation

267. One reason the failure to appreciate the importance of testing was particularly pertinent in this Module was seen in relation to the failure to use testing to lessen the detrimental impacts of isolation in NI. Aspects of isolation and its detrimental impacts have been addressed in the context of the wider UK submissions above. In order to understand the very personal and human issues which this involved ensure it is appropriate to consider raised of this failure it is important to acknowledge the significance of the issues around healthcare isolation as identified by NICBFFJ members.

268. The extreme consequences of being isolated from loved ones, particularly after they have contracted COVID, was evident from the statement from Fidelma Mallon **[INQ000494735]** These include not only significant distress at being separated from a loved one in their hour of need, but also the ability to intervene with aspects of care to ensure that basic steps are taken, including administering the correct medicines at the correct times, including medication required to avoid discomfort such as eye drops. It was also significant in monitoring decisions about end-of-life care and whether they had been taken lawfully and appropriately in practice.

269. Martina Ferguson's statement **[INQ000360941]** and oral evidence [**39/109]** also eloquently highlighted issues with isolation on part of NICBFFJ members, and positively demonstrated, in her evidence about her access to her mother in hospital, the important beneficial impacts that permitting contact with those in the position of a care partner could have for patient care.

270. Evidence suggests that the Department, or the PHA, failed to appreciate the very real detrimental consequences of such long term isolation. When presented with options for easing such isolation, their response lacks any sense of urgency.

271. One issue raised in this particular module was the failure to utilise testing as a measure which would allow an easing of the isolation of the most vulnerable, particularly those in healthcare facilities. A PHA note to address this issue **[INQ000343958]** notes that "*NHS England has offered testing to visitors to maternity settings and in end of life care*" from January 2021 and noted that an NI "*testing team met with an official from NHS England to discuss this in January 2021.*" This PHA note was dated July 2021, six months after that meeting. It was not until September 2021 that a letter from the CMO was issued to allow for such testing in NI [INQ000485720/38§104]

272. The PHA Chief Executive accepted that this appeared to be a lack of timeliness in dealing with this issue, and further accepted that NICBFFJ would find it concerning that this had not already been identified and the reasons for it discussed within the PHA to identify areas for improvement. **[26/107/10-26/108/24]**

Pregnancy

273. One issue which cut across a number of issues in this module was the treatment of those who were pregnant.

274. The extent to which there were deficiencies in NI healthcare and its treatment of pregnant women during Covid was demonstrated in a number of respects in the evidence of Catherine Todd (INQ000494257 and transcript **Day 3/1/9-3/29/12**):

(i) Her concerns were repeatedly not listened to or given the appropriate weight;

(ii) That she was denied a CTG scan, notwithstanding the concerns she had repeatedly raised, because she was one day short of the threshold;

(iii) For very significant periods, he partner and her baby's father was denied entry to the hospital with her. He was only permitted in a few hours after their baby Ziggy was born. Even then he was told "you shouldn't even be here, we've already bent over backwards for you, you shouldn't even be here." This amounted to a failure to recognise the very real detriment for pregnant women and their partners caused by the strict limits imposed.

(iv) After being told she required an urgent C section, and being prepped for surgery, she was left for around an hour while medical staff gave priority to another emergency.

(v) There were repeated failures to explain what was going on throughout that night and what the prospects for their baby were;

(vi) There was insistence on PPE that does not appear justified by any risk or guidance;

(vii) After Ziggy's death Catherine and TJ were not provided with significant information, including about a cuddle cot.

(viii) Due to the lack of a paediatric pathologist, Ziggy's remains were sent to England for a post mortem. For a period the location of his remains could not be identified, causing them significant distress.

275. Catherine's account was a comprehensive description of a complete failure, in multiple respects, of the healthcare response to Covid for a young pregnant mother and her baby. She describes what amounted to a lack of rationality or compassion in many aspects of the Covid response, as well as a failure to proactively protect life, or to listen to the patient and place weight on their views and concerns, in a number of respects.

276. It beggars belief that there was a lack of understanding about the risks associated with Covid and pregnancy in NI until, at least, August 2021 – giving rise to the strong inference that there was insufficient research and focus on covid and pregnancy more generally.

277. Memorably, Catherine's evidence was that such is the state of the healthcare system in NI that as a pregnant woman in NI in 2024, she did not feel safe.

278. We invite the Inquiry to make findings that will assist in ensuring that such treatment is never repeated, as well as recommendations in support of this aim, in the section on recommendations below.

Inability to address NI in time available in this Module

279. There have been a number of fundamental difficulties in addressing the healthcare response specific to NI during this module of the Inquiry. The problems with the healthcare system are so significant that Covid did not break the system, it merely exacerbated existing problems. **[33/112/21-24]** This comment from the former Health Minister was made in relation to emergency care, but also has obvious resonance for the system as a whole.

280. The small number of witnesses from whom the Inquiry heard in relation to NI issues was compounded by the failure of key witnesses to have properly engaged in a process of self-reflection, meaning that they were unable to adequately address many of the most significant issues that the Inquiry is considering. The lack of data from NI at times

reinforced the difficulty in establishing what in fact occurred, and therefore what went wrong. Perhaps as a consequence of this, a repeated refrain from expert witnesses was that they were unaware of the situation in NI. All of this serves to hinder the Inquiry in its ability to establish what happened and how it could or should have been improved.

281. This all suggests that informed consideration of the NI healthcare response would require a more in-depth examination, hearing from a greater number of witnesses, and informed by experts with specific expertise on the NI healthcare system, considering evidence from more witnesses, including those across a variety of entities and levels of authority, in an attempt to understand what in fact occurred during the pandemic.

282. Despite this, there are key conclusions which can be drawn, and important recommendations which we consider the Inquiry can and should make.

SECTION NINE: RECOMMENDATIONS

283. The scale of change needed to ensure that healthcare services are in a better position to meet the next pandemic cannot be overstated. At the centre of any change in the future, the inquiry must address the issue of resourcing. Without addressing this fundamental issue, the underlying resilience of the healthcare sector will not improve and any other changes are unlikely to be realised in practice without sufficient capacity to achieve them.

284. We urge that the recommendations below can, and should, be made by the Inquiry on the basis of the evidence heard in Module 3. Some of the recommendations set out below are highlighted as 'urgent'. We submit that should be made by the inquiry as soon as possible, rather than within the Module 3 report. In our view, each of those recommendations is (a) uncontroversial on the basis of the evidence heard in Module 3 and (b) required as a matter of urgency.

285. **Recommendation:** There needs to be substantial investment in the UK healthcare systems to raise their level of resilience and capacity to that necessary to enable the UK to properly respond to future pandemics.

286. **Recommendation:** Government, the DAs, and the health services, should have as a central aim of emergency planning that there must be sufficient capacity to ensure that services are not overwhelmed. The governments and relevant institutions should be asked to publish an action plan within 12 months, recognising this central aim and how it is to be achieved, and within what timescale.

287. **Recommendation:** Capacity across 999, NHS 111 and primary care during 'normal times' must be strengthened to ensure that there is sufficient resilience within the services to be able to handle a future pandemic. This should include increasing the workforce across these services.

288. **Recommendation:** The Government and DAs should allocate greater capital expenditure to replace or upgrade existing facilities to facilitate isolation and separation of patients, and specifically to provide adequate ventilation. In addition, temporary and mobile solutions should be implemented to mitigate the particular problems of poor ventilation in the short to medium term.

289. **Recommendation:** The Government and DAs should publish open and transparent reports, periodically reviewed, setting out what PPE and therapeutic stockpiles and reserves are available and how they are managed.

290. **Urgent recommendation:** By 1 March 2025, UKHSA, NHSE, DHSC and other public health agencies, with the benefit of multi-disciplinary input from experts in physical sciences, should revise IPC guidance in the NIPCM and HTM guidelines to ensure:
(a) recognition of the role of airborne transmission of SARS-Cov-2; and
(b) there is appropriate guidance on measures to limit airborne transmission of respiratory viruses such as Covid-19 including the use of respirators, improved ventilation and air cleaning devices in healthcare settings (both clinical and non-clinical).

291. **Urgent recommendation:** Tailored updated IPC guidance should be urgently developed in relation to (a) ambulances (b) call centres (c) primary care settings.

292. **Recommendation:** As addressed above, there is a clear need for much greater data gathering and analysis on various healthcare discrimination and inequality issues. We urge the Inquiry to make this wide-ranging shortcoming clear and to recommend that data gathering on ethnicity and disability in particular should be substantially increased.

293. **Recommendation:** The Government, the DAs and the four healthcare systems must put the recognition and combatting of structural and institutional racism and discrimination, including gender inequality, at the centre of human resource and policy formulation, and emergency planning. In practice this means that all policy and planning matters should include express statements as to how they have considered and dealt with such issues. A recommendation in such terms would go some way to minimising problems highlighted by the evidence regarding staff allocation, inappropriate PPE provision, the use of inappropriate medical devices, and inappropriate 111 algorithm questions.

294. **Recommendation:** The Inquiry should recommend specific planning to address inequalities within the NHS 111 and 999 algorithms and the introduction of data monitoring for inequalities for 999 and 111 services.

295. **Recommendation:** Employment contracts in all areas of healthcare provision should ensure so far as is possible that conditions are fair and employment is not precarious.

296. **Recommendation:** Access to healthcare should not be subject to 'hostile environment' policies.

297. **Recommendation:**, Structural and institutional discrimination should be recognised as systemic, and to be addressed by government and institutions, and not the responsibility of those affected. We urge the Inquiry to recommend the adoption of a cross-government strategy to combat structural and institutional discrimination.

298. **Urgent recommendation:** We urge the Inquiry to recommend an urgent review of NHS 111 and 999 algorithms to determine whether there remain discriminatory questions, such as those which assume that the caller has white skin.

299. **Urgent recommendation:** It is clear from the evidence the Inquiry has heard and the experience of our family groups that was a widespread problem of inappropriate DNACPRs having been imposed during the pandemic. We urge the Inquiry to recommend that there is a UK-wide programme to urgently review all DNACPRs imposed during the pandemic.

300. **Recommendation: I**ntroduction of UK-wide guidance on DNACPR integrated within the framework of end of life decision making in accordance with the ReSPECT process, which should go some way to ensuring that it is not viewed as a proxy for the inappropriate withholding of other treatments.

301. **Recommendation:** Embed Advanced Care Planning and use of DNACPRs in medical and nursing training. This should include training regarding the interaction with decision making under the Mental Capacity Act and how this would relate to ceilings of care discussions.

302. **Recommendation**: Clear guidance on the requirement to consult with family members in respect of DNACPRs and improved record keeping of consultation and engagement

303. **Recommendation:** Improved data collection to monitor the use of DNACPRs and the scale of inappropriately applied DNACPRs.

304. **Recommendation:** All emergency planning must expressly recognise the specific needs of disabled people and how they are to be met. In terms of healthcare, governmental responsibility should reside with the Minister for Health and the Minister for Social Security and Disability, and should be specifically added to their portfolios and those of their counterparts in the DAs. At an institutional level there should be designated managers for these responsibilities within Trusts and other organisations.

305. **Recommendation:** There is a clear need for strengthening of both clinical oversight and training for NHS 111 services.

306. **Recommendation:** One aspect of learning lessons and preventing recurrence is ensuring accountability. One aspect of this is establishing the truth of what occurred. The Inquiry should therefore make very clear that the NI healthcare system was failing those in the jurisdiction in advance of the pandemic, that this was primarily due to political decision-making as well as political dysfunction, and that this set the scene for the healthcare response, and in particular ensured that the response was hindered from the outset.

307. **Recommendation:** The Inquiry should explicitly and critically comment on the lack of self-reflection on the part of key NI actors as a distinct concern in the M3 report. We consider that such comments form an element of truth telling and therefore contribute to accountability. The Inquiry should additionally make recommendations to ensure that informed self-reflection, and where necessary investigation, should form part of any future pandemic response.

308. **Recommendation** The Inquiry should confirm that there were a number of flaws which underpinned IPC Guidance for too long, including the mistaken views among those, primarily with a medical background about the size and properties of "droplets", whether aerosols were infectious, and the initial failure, and then significant delay, in acknowledging that far field transmission was an issue, at least in indoor settings with limited ventilation. Relatedly, the inquiry should make clear that, in any future pandemic response, it is not sufficient to conclude that "the mid-point of scientific opinion" is most likely the correct conclusion. Steps must be taken to ensure that those with particular expertise in a field who have something relevant to say are listened to. This may require a dedicated mechanism to be established in a pandemic in order to consider and review information provided by such experts.

309. **Recommendation:** We invite the Inquiry to find that the failure if any NI entity or individual to accept responsibility for IPC Guidance was a flaw in the healthcare response, as it undermined the prospect of accountability. The Inquiry should further recommend that, in any future pandemic, steps must be taken to ensure that senior local actors or agencies are accountable for decision-making in respect of issues such as (a) determining likely routes of transmission; and (b) the extent to which IPC guidance is founded on those routes. This should be the case even where there continues to be reliance on UK entities for the scientific underpinnings of such decisions.

310. **Recommendation:** The Inquiry should do the following in response to the issues of nosocomial infection in NI.

c. It should make clear that failing to identify, track and respond to nosocomial infection was a significant flaw, and should identify where accountability lay for these failings.

d. We consider that at least some of the cause of nosocomial infection will have been the mistaken approach of dismissing the risk of far field transmission, and the focus on contact/droplet routes of transmission, as well as AGPs, for far too long. The Inquiry should identify that the content and development of IPC Guidance involved significant failings, and this will necessarily include criticism of the content and development of IPC guidance, and in particular the initial failure, and then significant delay in acknowledging that far field transmission was an issue, at least in indoor settings with limited ventilation.

e. The Inquiry should recommend that ventilation needs are fully met in any new-build hospitals, and that hospitals should be designed with a view to the modes of transmission of diseases.

311. **Urgent Recommendation:** Because information is required for an effective response, the Inquiry should recommend that work is undertaken to:

(a) Establish with more certainty the extent to which measures, including portable air cleaners, upper room UV lamps, and far UVC lamps are effective at limiting nosocomial infection, and

(b) Identifying how such devices should be deployed in healthcare facilities to best effect.

312. **Recommendation:** The failure to collect data in relation to multiple issues by the NI authorities amounted to a flaw. The inquiry should make this clear in its findings. The failure to ensure data relating to equalities, and specifically that data captures and identifies inequalities, should be identified as particularly egregious. Identifying this as a failing provides a necessary (though not sufficient) level of accountability.

313. **Recommendation:** Against a background of evidence suggesting that the failure to collect relevant data was systemic, the Inquiry should recommend that there is should be clarity in relation to whose role it is to identify what data is required to inform an effective response, to identify whether the appropriate data is being gathered or can be obtained and disseminated, and who is empowered to take steps to ensure that it is gathered and disseminated in practice.

314. **Recommendation:** We have noted the former NI DoH Minister's support for a retrospective investigation into the use of DNACPR during the pandemic in the body of our submissions. Whether or not that step is taken, the Inquiry should recommend that, whilst it has been unable to determine what occurred in individual cases, the extent and nature of reports of inappropriate use of DNACPR has understandably caused deep and enduring concern, and the appropriate response is to ensure an in-depth effective investigations of such complaints, comparing policy against practice, so as to ensure the utmost clarity in communication between Health Care Professionals and their patients in relation to decisions about emergency resuscitation.

315. **Recommendation:** For the same reasons as identified in relation to DNACPR, it is clear that simply looking at what policies and guidance were formally in place is insufficient, as there must also be scrutiny of what happened in practice. As a result, any investigation in relation to DNACPR should include all end of life decisions where concerns have been raised.

316. **Recommendation:** Given the very real detrimental impacts caused by enforced isolation from family and friends by reason of visiting restrictions, and the detriment caused not only to mental but also to physical health, we would invite the Inquiry to recommend that:

(a) Where such conditions of isolation are imposed, an impact assessment should be required for all (irrespective of protected characteristics) identifying why the benefits of the measure outweigh the inevitable negative effects.

(b) Furthermore, such isolation must be kept under frequent and regular review.

(c) The availability of options to lessen the conditions of isolation are kept under regular review, whilst any and all potential developments or measures that could be used to lessen or end isolation must be prioritised.

317. **Recommendation** We note the explanation provided in Catherine Todd's case, in relation to the death of her newborn son Ziggy, that there was a lack of understanding about the risks associated with Covid and pregnancy in NI until, at least, August 2021.

(a) We consider that in the case of a new and life-threatening virus such as Covid, the precautionary principle should apply.

(b) Those who are pregnant must not experience delays in their treatment, but rather benefit from the same if not greater oversight as they would otherwise have had.

(c) Birthing partners are care partners, are essential figures of support for pregnant women, and particular importance should be attached to their ability to attend scans and hospital visits in relation to pregnancy.

CONCLUSION

318. The overarching context of our healthcare systems as at 1 January 2020, was uncovered by the evidence in Module 1: a lack of resilience and virtually no planning for a non-flu pandemic. As asserted in our submissions above, this Inquiry must make that clear in its findings on Module 3 and address it in recommendations.

319. In terms of resilience, the central and obvious problem is resourcing. How a society raises its funds, sets its budget and allocates its expenditure is pre-eminently for the democratic process. How that allocation affects outcomes relevant to a public inquiry is however, a matter upon which it should and must make findings.

320. In the context of this Inquiry, the abject lack of resilience and capacity, in terms of staffing, beds, the physical estate – indeed all relevant metrics – must be highlighted to fulfil the Terms of Reference. A failure to do so will not only ignore the elephant in the room, but minimise pressure for change. As we understand the evidence, resilience and capacity were not only chronic and acute problems as at 1 January 2020, but remain so today. That is alarming.

321. How is the Inquiry to express this problem in a clear and understandable way, and a way which does not appear to impinge on the democratic process? In our submission, it can best do so by reference to the position of the UK health systems as compared to other similar and wealthy nations: bottom of the league.

322. It can also draw attention to particular effects caused by resource deficits: the 'overwhelm' point set out in Section 2 above. It should brush aside the nonsense of the former PM and Health Secretary who have rewritten history to serve themselves. The fact that the whole system did not grind to a halt does not mean that many parts of the service were not overwhelmed and did not cope at particular times, with fatal consequences. We have heard of substantial percentages of 111 calls going unanswered, huge delays in ambulance despatch and attendance times, escalation to critical care rendered impossible

by capacity, lack of provision for critically ill patients with learning disabilities and dementia: all examples of system overwhelm.

323. Similarly, how can the Inquiry make recommendations about future resourcing? Firstly, the Inquiry should recommend that the Government and Devolved Administrations should issue annual reports regarding a range of capacity metrics – per capita numbers of doctors and nurses, beds and ICUs, for example – compared with other OECD countries. Secondly, the Inquiry should recommend that the Government and DAs commit to funding the healthcare systems to significantly increase capacity to levels which can efficiently meet business as usual demand, ground an adequate emergency response, and reflect our international standing.

324. With respect to planning, the Inquiry should recommend that the Government and DAs ensure that there are comprehensive, open and transparent healthcare system pandemic plans which address each relevant area, and which are integrated with other healthcare emergency planning and whole system plans. The plans should be published and reviewed periodically.

325. The Inquiry should make clear that resourcing and planning should learn from the past, but not only meet the challenges of past pandemics or known viruses. Planning must be based upon Disease X.

326. The families have been particularly alarmed regarding the evidence about IPC, discussed at Section 3, and this is an area which cannot wait. We have called, jointly with other CPs, for interim recommendations to be made on this subject now.

327. In our submission, it is axiomatic that where a dangerous new disease emerges, an absence of evidence must not be looked at as evidence of absence. Despite protestations to the contrary, there are three key areas in which this occurred. Firstly, despite early evidence that Covid was being transmitted asymptomatically, these reports were either doubted or minimised. Gathering evidence that transmission is asymptomatic, and if it is, how significantly so, may well be difficult. That should have prompted a precautionary approach. Secondly and similarly, the issue of aerosol transmission. To this date, and remarkably, there remains some controversy concerning its role. Once again, the speed of transmission and the view of many eminent experts from the outset, should have informed policy makers to take a precautionary approach. No 'standard of proof' should have been deemed relevant. Thirdly, and relatedly, the role of masks. It is clear and obvious in laboratory conditions that higher grade masks protect the wearer and the patient more than simple paper masks. The fact that there are practical complications which affect

the relative effectiveness in real life circumstances is a separate issue which called for other research and solutions, not a pretence that better masks could not provide better protection.

328. In all three of these areas, the evidence suggests that baseless assumptions were made on experience from previous diseases, and a lack of evidence, rather than taking immediate precautions and urgently seeking robust empirical evidence. In all three areas, we submit that the failure to take a precautionary approach was influenced by resourcing: if there was a lack of clear evidence of asymptomatic and aerosol transmission, and controversy as to whether FFP3 masks performed better than FRSM masks in practice, then it was easier to concentrate on hand washing (which turned out to be of minimal effectiveness) and to recommend that scarcely available FFP3s should only be worn in AGP environments.

329. In our submission, the Inquiry should call for an immediate revision of IPC policy, as an Interim Recommendation. Modes of transmission should not be assumed from previous diseases, and there should be a precautionary presumption where there is an absence of evidence, together with provision for urgent evidence gathering to make the position clear. Similarly, resource constraints may well impact on the immediate response to transmission, but they should not be allowed to influence what in fact is required. A shortage of appropriate masks may well affect the ability to safeguard healthcare workers and patients until supplies can be found but should play no part in determining whether they are actually required.

330. From the evidence, the importance of ventilation in preventing transmission has been poorly understood and recognised in the past. Relatively straightforward improvements in hospital ventilation and air filtration are likely to significantly reduce nosocomial transmission in both normal and emergency times. In all four of our healthcare systems, much of the physical estate has been described as crumbling. Inevitably, older buildings tend to have poorer ventilation systems if they have them at all. In our submission, the Inquiry should recognise the need for greater capital expenditure to replace or upgrade existing facilities. In addition, it is apparent that available temporary and mobile solutions can mitigate this problem in the short to medium term.

331. With respect to PPE the evidence is clear that such stockpiling as there was, related to flu. There appears to have been little knowledge of what was in the stockpile, no stock control – with an unknown proportion out of date - and no distribution plan or management. Plainly this illustrates the lack of capacity and planning referred to above. To some extent, what should be stockpiled, what will be necessary for the next emergency, and when, will

remain unknown. However, that does not preclude planning and decisions on appropriate levels of provision, and the systems to control it. Some required items will be more predictable than others: masks, gowns and gloves for example. Maintaining plans for emergency supplies, surge and hibernated manufacturing, should be more straightforward as these are less resource intensive. The Inquiry should recommend that the Government and DAs should publish open and transparent reports, periodically reviewed, setting out what stockpiles and reserves are available and how they are managed.

332. The Inquiry has heard much evidence concerning structural and institutional racism, relating to the disproportionate impact of Covid on BAME healthcare workers, and disparities of outcome for people from some ethnic minorities. Some of the underlying issues are societal and beyond the scope of this Inquiry, but many are not. The high proportion of ethnic minority healthcare workers is widely known, yet simple issues such as PPE designed for Caucasian males, or a lack of proper risk assessments, have gone unresolved. Similarly, it is well known that access to healthcare is not a level playing field for people from different communities. Yet we have heard evidence of algorithmic questions asked on 111 services, and the use of medical devices, which are appropriate to white people, but not Black and brown patients.

333. In the next module we will hear evidence of 'hard to reach' communities with respect to vaccines and therapeutics. People from marginalised communities are not so much 'hard to reach', as precluded from access to healthcare by barriers of discrimination. Putting responsibility for disparities of access and outcomes onto marginalised people, rather than public and healthcare systems, is itself a manifestation of structural and institutional discrimination.

334. It is right that the Inquiry should recognise that there are deep-rooted issues of structural and institutional racism which cannot be resolved by the process. But there are many elements of such discrimination that can be recognised by the Inquiry's fact-finding, and some which can be addressed and resolved by recommendations. At a high level, the four healthcare systems should be required to gather sufficient data to analyse how structural and institutional racism affects their workforces, and their patients. The healthcare systems should be required to periodically report on these issues, and measures taken to resolve or mitigate safeguarding of workers and patient access problems, and disparities of outcome. At a more granular level, the Inquiry should recognise from the evidence that ethnic minority staff were more likely to be deployed at the sharp end of the system, even making adjustment for relative populations, than white staff, and more likely to be in insecure employment. The Inquiry should recognise that institutional racism has occurred through the failure to provide PPE and medical devices

appropriate to people with different racial characteristics or cultural needs (or gender), and the failure to ensure equal access to healthcare for migrants and those whose first language is not English, and to ensure that access algorithms, such as 111 call handler questions, are not predicated on the caller being white. Recommendations can address each of these individual issues.

335. The Inquiry has heard much evidence concerning disability discrimination, and disparity of outcomes. Although there are issues which overlap, different forms of discrimination are distinct, and those subject to discrimination should not be treated as a homogenous group, or grouped as 'vulnerable' people. The Inquiry should address the different issues separately whilst recognising intersections.

336. Shockingly, the Inquiry has heard evidence regarding the failure to support and treat people with learning disabilities, Down syndrome and dementia. The Inquiry should recognise that there was insufficient capacity and planning to support people with disabilities, and this has been recognised as a factor in increased mortality. The Inquiry should call for the four healthcare systems to gather sufficient data regarding provision and support for those with disabilities, and to produce periodic reports and action plans as to how such discrimination is to be tackled. Importantly, the Inquiry should highlight that combatting disability discrimination requires increased capacity of specialised staff, and robust policies to combat the inappropriate consideration of disabilities with respect to escalation of treatment.

337. In terms of care planning, in particular for older people, and those with comorbidities and disabilities, the Inquiry should recognise widespread concerns about the application of DNACPR forms, and the apparent confusion with relating them to other treatments. There is plainly a pressing need for clear published policies regarding individualised care planning, and that it is regarded as a partnership between patient (or their loved ones where appropriate) and clinician. The Inquiry should recommend that there must be a joined up approach to distinct issues of care planning, including treatment escalation, DNACPR, and end of life care, perhaps through the use of a single, standardised form or folder in each healthcare system.

338. The families recognise that many healthcare staff did everything in their power to respond to and mitigate the effects of the pandemic. Many of them paid with their lives. Others have Long Covid. The effect on their wellbeing at the time and now has been immense. Many of the families we represent are themselves healthcare workers, or the bereaved families of healthcare workers who died. The families had the right to expect

better from a properly funded system with adequate planning. They demand better for the future.