Witness Name: Toby Lewis
Statement No: 1
Exhibits: 11
Dated: 3 December 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF TOBY LEWIS ON BEHALF OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

I, Toby Lewis, will say as follows: -

1. I have been asked to prepare this statement, pursuant to a section 9 notice issued to the Trust on May 9, 2024. I was Chief Executive of the Trust at the time covered by the questions issued. I remain a Chief Executive in the NHS, working now in another Trust: Rotherham, Doncaster and South Humber NHS Foundation Trust. My statement has been provided to the Sandwell and West Birmingham Hospitals Trust ('the Trust') prior to issue to the enquiry, and I infer from that process, that they have chosen not to question the veracity or completeness of my account, indeed they have assisted in its preparation, and it has been read for accuracy by my successor who is also named within it, Richard Beeken.

Context

2. Before addressing the specific questions asked, it may assist the inquiry to clarify the situational context. The Trust provides acute services to a quarter of Birmingham and all of Sandwell, principally from two hospital sites. This work is undertaken within what was then considered the Black Country and West Birmingham system, subsequently separated into distinct Integrated Care Boards. In managing the pandemic wave one (the period of the events in question) we worked very closely with neighbouring hospitals in Walsall, Dudley and Wolverhampton. The critical care network operated over a larger geography,

centred on tertiary hospitals in Birmingham, including the Queen Elizabeth. That hospital group (UHB) had been asked at the time concerned to develop a 'Nightingale Hospital' for the wider Midlands, modelled on initiatives established in London.

3. Sandwell and West Birmingham Hospitals saw a substantial volume of wave one Covid-19 patients, including large numbers of asymptomatic patients in general beds. In the first fortnight of April 2020, we had the second largest number of confirmed Covid-19 admitted patients in NHS Midlands. Numbers diagnosed rose steeply during the latter part of March 2020. We were working to trajectories of intensive care volume growth expected to rise to 400% of base capacity during April.

4. The Trust established structured control systems across its clinical management to manage safe care during this period, with oversight of all operational and external relational matters. As Chief Executive, I acted as 'gold command' through this period, with Liam Kennedy, our Chief Operating Officer, as 'silver command'. Clinical involvement in all material decisions was paramount, and, given intensive care pressures on our sites, the clinical lead for those services, Dr Nick Sherwood, joined decision-making meetings which he would not ordinarily have been involved in. His expertise and dedication was, in my view, noteworthy, even at a time of many colleagues needed to step up in an the unprecedented situation.

5. From March 26, 2020, onwards the Trust, through my own actions and those of others, actively sought to establish how we could obtain ventilators consistent with the agreed regional plan for our intensive care expansion. We were not alone in pursuing these questions with colleagues in NHS Midlands (Julie Grant, Rebecca Farmer, Dr. Nigel Sturrock, Siobhan Heathfield, Jeff Worrall, Dale Bywater) and through the critical care network (Dr. Nick White). To my knowledge and memory, Chief Executives colleagues from neighbouring hospitals (Richard Beeken, David Loughton, Diane Wake) sought similar clarity. We made two approaches in particular: one sought to enquire whether less affected regions in England might be prevailed upon to 'loan' us some ventilators, a second sought to obtain ventilators from the ambulance service (via Mark Doherty – Chief Nurse). There was not an option for us to simply procure ventilators, both because of international

supply chain issues, and because we had been instructed to operate through nationally procured (and allocated) approaches. This position was publicly confirmed on May 2nd (Exhibit TL/01a [INQ000478803]) but had been indicated repeatedly informally beforehand, specifically in relation to ventilator supply. From March 31, 2020, and repeatedly thereafter I raised concerns in writing about what appeared to be a 'just in time' supply model in which a Trust needed to demonstrate in effect that it was 'falling over' before it would be prioritised for equipment assistance. This raised questions about the usefulness of the trajectories and plans so diligently submitted and re-submitted to NHS Midlands.

6. Our need for ventilators had been duly registered in the submissions made to NHS Midlands. Our projected figures were wholly consistent over time, and consistent with our agreed plans. Until the time specified in the following paragraph, I had no forewarning of who, how, or when decisions about allocation or specification would be made. This made it difficult to prepare teams of staff for receipt or manage their understandable anxiety about our future readiness.

7. On April 6, 2020, we received ventilators, which we had been alerted to on April 3, 2020.

8. We received 30 Shangrila 510 ventilators, made by Beijing Aeon Med. These were directly sourced by DHSC/NHSE or another national body from the Chinese supplier and delivery was organised through the national supply chain via MOD Donnington.

9. The scale of ventilator delivery made to the Trust was 25% less than we had asked for and required for our approved plan. It was unclear how this decision had been made or by whom.

10. Our critical care clinical teams had been central to formulating the plan for how many ventilators would be needed, given the scenarios for growth we ourselves developed. These scenarios were also informed by regionally and nationally specified assumptions. This plan was tested and approved through the command structure cited at paragraph 4 above.

Neither the Trust's management, nor our clinical teams. had any involvement at all in determining which makes and models were procured or allocated to us.

11. On receipt, our engineering and clinical teams sought to assess the functionality and capability of the equipment received. Limited information was available to work with. Initially the Shangrila ventilators were unusable as supplied as the oxygen piping / connectors were not UK standard, the oxygen fuel cells were unusable without modification and the supplied breathing circuits were multi-use but had no sterilisation instructions. There was no UK representation of the parent company and no one we could obtain advice or consumables from. We then invested significant time modifying the ventilators so we could even test them in our engineering workshop, let alone use them on a patient. We also invested significant time trying to construct a disposable breathing circuit that could safely be used by utilising available components from assorted UK suppliers

12. Dr Sherwood confirms that "we applied for additional ventilators from the National stockpile. On April 3, 2020, we received notification of delivery of two potential types of ventilators. While it was relatively easy to find information on the Flight Medical it was very difficult to find anything on the Shangrila. I was able to find some information from the NHSE Allocation team for London. I shared this with colleagues in the Black Country as we had all been allocated Shangrila. We did not ask for the Shangrila – it was selected for us by NHSE, and we had no choice in the procurement. I do not know why we were allocated these ventilators as opposed to more appropriate ICU ventilators. I do not know where the more appropriate ventilators were allocated to and how this judgement was made." (note provided to the Trust in compiling this statement)

13. A precis of the issues set out to me by clinicians was twofold:

    - The Shagrila ventilators ceased to function without warning on occasion [at the time this was hypothesized to be a connection issue]

- The Shangrila ventilators were not able to vary upwards or downwards the supply of oxygen to patients, which made them not useful to our clinical purpose

The letter provided under question 3 renders a more fulsome summary of contemporary clinical concerns (Exhibit TL/01 [INQ000508296]). My own summary associated with the meeting discussed under paragraph 16 below is appended (Exhibit TL/02 [INQ000503324]). That meeting benefitted from clinical summaries from Trust clinicians, and a variant view from an outside clinician (Exhibits TL/03 [000503322], TL/04 [INQ000503321] and TL/05 [INQ000516843).

14. The delivery of the ventilators we received came with just two days of consumables necessary to use such ventilators and no information about future consumable supply. This, in addition to the underlying issues above, meant that we were unable to plan to use the ventilators to the intended extent. Any use of the machines was exploratory and under close senior clinical supervision over the latter part of the week commencing April 5, 2020.

15. In view of the issues that we faced, Liam Kennedy and I were in regular dialogue with the clinical leadership team in intensive care. Pursuant to other routine discussions with NHS Midlands, for example over the Nightingale Hospital, I sought clarity over whether other sites were also raising issues of concern about ventilator allocation and capabilities. I indicated that I was minded not to insist on the use of those issued to us until our concerns had been satisfied. I was encouraged to approach other hospitals where I was assured the new ventilators (bear in mind a possible range supplied) were already in use. Such information as we were able to obtain did not corroborate their use and reinforced our concerns. At Exhibits TL/06 [INQ000503320], TL/07 [INQ000503325], TL/08 [INQ000503319], TL/09 [INQ00050318] and TL/10 [INQ000503323] relevant material shared between partners at this time is included. I was made aware of the sensitivity of such concerns by NHS Midlands, which I took to be an encouragement to discretion, and appropriately so. From April 7, 2020, and again on April 9, 2020, I indicated to NHS Midlands that we would in all likelihood need to return as unusable the ventilators provided by the national process.

16. Dr Sherwood and his colleagues summarised their 'first week' concerns to me on April 11, 2020. On Sunday April 12, 2020, I chaired a review meeting with Drs Sherwood and Hulme, alongside the medical director, Professor Carruthers, Mr Kennedy, and the regional medical director of NHS Midlands, at my invitation. This meeting was a formal risk assessment of the position we faced and the role if any of Shangrila ventilators. At the time of the meeting the following weekend was expected to see a further 'super surge' peak in ventilator needs locally. At Exhibits TL/02 [INQ000503324], TL/03 [INQ000503322], TL/04 [INQ000503321] and TL/05 [INQ000516843] I append material that informed this meeting, emails relevant to it and the decision note from it (which was shared that evening with peers at Walsall who were also engaged in discussions over the machines' safety). *The meeting concluded we would immediately cease any trial or other use of Shangrila ventilators* until at least Wednesday April 15, 2020, pending discussions nationally.

17. As this implies when we met on that Sunday, we were under the impression that these concerns were now being assessed nationally and knew that a meeting with the new national clinical director for intensive care had been set for the following day (Monday April 13, 2020). Our concerns were such that we felt we needed to make a local decision, notwithstanding that, as we were unclear whether that meeting would make a decision, and if so when it might be communicated. We were however confident that our clinical presence in this national meeting would alert peers to our concerns.

18. I append a copy of the letter issued to Professor Ramani Moonesinghe, National Clinical Director for Critical and Perioperative Care since April 2020 (Exhibit TL/01 [INQ000508296]). This letter was issued by Dr Jonathan Hulme, who had attended the aforementioned meeting on April 13, 2020, and is a clinician at the Trust. It was sent direct and via email in a personal, albeit professional, capacity – and subsequently shared with me. I am given to understand that Dr Hulme was encouraged within the meeting to place his concerns in writing. Dr Hulme has confirmed to the Trust that no reply to the letter was received, albeit he briefly spoke with Professor Moonesinghe subsequently. The Shangrila ventilators' use in the Trust was not reconsidered after this meeting, as our clear understanding

was that our prior discontinuation had been endorsed and what we perceived as pressure on us to use these ventilators then ceased.

19. Neither Dr Hulme, nor I, have any knowledge of how it came to be in the possession of NBC News. When the referenced article was published, the Trust were asked by NHS Midlands to assess this, and were unable to shed light on how it had been obtained. I can confirm that the press statements cited in Midlands' news media were accurate reflections of authorised press releases, including quotes from me which were and remain accurate. It should be recalled that the arrival of the ventilators had been a central feature of the West Midlands' Mayoral Authority's press conferences, including on April 3, 2020, when I was the nominated NHS spokesperson. By the latter part of April, our concerns over intensive care capacity had lessened, and we were revisiting previous estimates of need, not least as we developed further use of CPAP/BiPAP approaches. Accordingly, the need to backfill the discontinued/removed Shangrila ICU ventilators did not arise.

20. Taking the question of patient need for ventilators to refer solely to patients cared for within the Trust, we can find no record of any patient whom clinicians identified as needing ventilation who was not ventilated. Assessing who needed ventilating with a novel condition required significant judgment, and it is possible that, on occasion, an individual clinician may have disagreed with their colleagues. However, no incident reporting, complaints, or coronial findings have been identified which give rise to suggest denial of treatment. Given the very detailed and intense interactions taking place about clinical care, and hospital flow, during wave one, it is my expectation that any such case would have rapidly been drawn to my own and others' attention. None were.

Lessons Learned

21. The Trust undertook several structured lessons learned activities. In particular, a wave one review in August 2020 and a second review in early 2021, after wave 2. Of relevance to module 5, the later review reflects on significant improvements in external coordination, visibility of stock, and engagement with Trusts: this is a

highlighted contrast to wave 1. Colleagues narrate the benefits of NHS Foundry. Internally, highlighted improvements in the accessibility across sites of pick-up locations for PPE, FIT testing and other essentials.

22. My own reflection is that, in respect of this equipment, and indeed Personal Protective Equipment, we needed to give further thought to how equipment purchased without our involvement is best tested prior to arrival or use. Further planning is needed as to how assurances from other procurers are novated and transferred to end users, such as Trusts. We benefitted from the outset of the pandemic from significant in-house clinical engineering expertise and took a position that regardless of provenance we should verify what we were sent.

Consideration of how such oversight responsibilities are distributed and communicated for any future stockpile, or national procurement, is a lesson to consider from these events. We cannot assume that improvement across the pandemic has inculcated the right behaviours of systems for future events.

23. After the decisions covered in this statement, we obtained information (April 16, 2020) about the specifications for ventilators, issued by NHS England. Clinical advice provided to me at that time (and reiterated in preparing this statement) suggested that the Shangrila ventilator issued to us would not meet the elements outlined below: and its inability to do so was arguably apparent from the details of the product on the supplier's website. This may suggest that the buying skillsets required and the evaluative capability to consider suppliers' offers in times of scarcity need further consideration.

Ventilation

a. 1. Must have at least 1, optionally 2 modes of ventilation a. Must have CMV.
i. b. The CMV mode must be either i. (ideally) Pressure Regulated Volume Control, or
ii. ii. pressure controlled ventilation (PCV) or
iii. iii. minimally a volume controlled ventilation (VCV).
iv.
v. c. PRVC/Pressure Controlled - a set pressure is delivered for the period of inspiration and the volume achieved is measured and displayed. Ideally PRVC, an adaptive mode **where the tidal volume is set** and the lowest possible pressure is delivered to achieve this volume. PCV where the user has to provide the adaptive control to achieve tidal volume is only acceptable **if the tidal volume delivered is clearly displayed and the user can set patient specific upper and lower tidal volume alarms** to alert to the need to adjust the pressure.

Above text is extracted from the referenced web document below.

https://www.gov.uk/government/publications/specification-for-ventilators-to-be-used-in-uk-hospitals-during-the-coronavirus-covid-19-outbreak?utm_source=42fad7bf-b36b-4bc3-9574-142740859072&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 3 December, 2024