Witness Name: Charlotte Hudd

No. Statements: 1.

Exhibits: 0

Dated 30 April 2025

UK COVID-19 PUBLIC INQUIRY – MODULE 6

WITNESS STATEMENT OF REVEREND CHARLOTTE HUDD

I, Charlotte Hudd, RCN member of Irrelevant & Sensitive, will say as follows:

1. I commenced my nursing training in 2006 and qualified as a registered nurse in 2009. I spent time on wards before gravitating towards care home nursing, where I developed varied clinical skills looking after people with long term illnesses, mental health conditions and end-of-life needs. I have undertaken a number of courses which demonstrate my passion for end-of-life care. By way of example, in 2010 I secured funding for a leadership grant to improve end of life and palliative care. In 2015 I was made a Queen's Nurse and in 2021 I became a Mentor for the Queen's Nurse Aspiring Leaders' course. I qualified to be a Registered Healthcare Chaplain in 2020 and continue to be on the UK Board of Healthcare Chaplaincy register. After a period of discernment from 2018 I started a three course at Theology college in 2021 to be ordained in the Church of England. I now work part-time as a receptionist/patient advisor in a GP Practice alongside parish curacy as a trainee vicar.

2. During the pandemic I fulfilled a number of roles. Initially, when the pandemic was declared in March 2020 I was working as a charge nurse at a nursing home in I&S and commuting from I&S. I left this role in April 2020 due to the pressures of the long commute and my worry that lengthy travelling was increasing my exposure to Covid-19. I wanted to ensure that I was closer to my family and so I undertook a role in ambulance control, answering 999 and 111 calls but I found that I missed face-to-face patient care. In August 2020 I returned to working in a nursing

home but this time I chose to remain I&S. I remained as a nurse in charge of a nursing home until June 2021 when I had to leave my role due to the impact the pandemic was having on my health and well-being.

Infection Prevention and Control guidance and ventilation

3. Until 12 March 2020, government guidance in England maintained that it was very unlikely that Covid-19 would enter care homes. Nevertheless, we kept a close eye on the news and the daily updates. When lockdown began, the home I was working in put a stop to visits. It quickly became clear that residents were suffering the effects of isolation as a result. When people living with dementia are upset or confused their distress can manifest as not eating and crying. It is very difficult to explain the rationale of any change to routine for residents who lack capacity and cannot therefore understand the reason behind any infection, prevention and control measures that are put in place such as social distancing or isolating in their rooms. It made following any infection prevention and control measures very difficult as did the need to be close to the residents when providing personal care. Some residents living with dysphagia (impaired swallowing function) would already be disposed to coughing and poor saliva control. There was little that we could do to limit or avoid this so we had to put our trust in the adequacy of the Personal Protective Equipment ("PPE") when it became available, and hope that it would protect us and them.

4. We would try and ventilate the home as much as possible, to allow fresh air in but the homes I worked in were old Victorian buildings. The ability to open windows wide was limited. Older residents would not want the windows open as they felt the cold and wanted to stay warm so we would attempt an air flush by opening the doors for a short period and then closing them. This presented its own challenges as the doors would have to be manned to prevent residents living with Deprivation of Liberty Safeguards ("DoLS") under the Mental Capacity Act 2005 from leaving.

5. The pandemic also had an impact on residents' socialising with the Home's community and their families. People with dementia and dual sensory deficits (hearing and sight) are already at risk of feeling isolated by virtue of their conditions. When human interaction is reduced further, we could see emotional pain, anxiety and distress through their experience of exclusion from their usual 'outside world' view. A rota was initially drawn up for residents to have social time in the lounge, and for family visits with people spread out and windows open. Eventually group activities in communal

areas were suspended and this resulted in many residents becoming fearful due to social isolation. For some, we could see a significant deterioration in their health and in others a failure to thrive. Among families, there were mixed feelings about how the Home should respond, some wanted visits and others wanted a stricter lockdown. The tough work of mediation fell to us.

6. The second home I worked in from August 2020 could cater for up to 21 residents. We would provide care for older people, people with dementia and those at the end of their life or requiring complex care, such as nutrition via a nasogastric tube, administration of medication via syringe drivers and tracheostomy care.

Visiting restrictions and the impact on residents and families

7. The rate at which the government guidance would change would be overwhelming at times and difficult to keep on top of. The toll of this additional administrative work became a burden as we tried to follow the daily public address and understand the implications for us and our residents in real time. It was frustrating that our sector was not given advanced warning of any changes that were being announced; we heard about them at the same time as the general public and this resulted in floods of phone calls from understandably anxious family members who were eager to visit their relatives. Many were heartbroken after grieving the loss of a relationship when they had been prevented from entering the Home due to the initial lockdown. For example, when the decision was announced that visiting restrictions could be lifted in care homes subject to a negative lateral flow test and the provision of PPE, the Home received dozens of calls to arrange visits but we had not had the time to figure out the logistics of how these visits would be managed in order to limit the risk of exposure to Covid-19, such as establishing a rota for visits by appointment. It was difficult to manage the families' expectations at the same time as managing the logistics of facilitating visiting. It placed a strain on relationships between the Home and resident's family members who would naturally feel frustrated and angry. The Home simply couldn't implement a new policy overnight. A lot of responsibility fell to the registered nurses to manage the risks. I rigorously followed the requirements to risk assess each relative, to ensure a lateral flow test was administered and a negative result secured and the individual was wearing appropriate PPE before a visit could take place.

8. During the infection spike in January 2021 I was adamant families should have a timely visit and risk assessments were made on a case-by-case basis. These were the most

sterile end-of-life visits I have done in my career but the main thing was that they got to say goodbye to their loved ones. Some staff were initially uneasy with my decision to allow family members in to visit their dying relatives. I invested a lot of time in explaining the purpose of risk assessment, ethics and safety issues. I wanted staff to know that I was supporting their welfare and safety but I also needed to balance that with humanity and feeling towards the residents. I took full responsibility for escorting the family visitors in, making sure that they had a negative lateral flow test and were wearing PPE and ventilating the Home as much as possible. I explained to staff that we were allowing funeral directors into the home and that there was no difference in safety to allowing a family member in to say their last goodbyes. I recall a resident dying 2 hours after their loved ones came to visit and I remember thanking God for Him helping me hold my nerve and allowing them in.

Locked in arrangements

9. The Home had managed to avoid an outbreak of Covid-19 until January 2021 when a new variant of the virus led to a surge in Covid positive cases nationally. At one stage in early January 2021, 95% of the Home's staff were off work because of Covid related absences. I recall arriving on shift and it was the fourth long day I had done in the past five days. I was told I was now the last nurse standing. My colleague, who had just tested positive for Covid-19 stood outside in the dark, freezing cold and handed over to me through the crack of an open window.

10. I then realized that there was no management in the Home and no other nurses were available. We had no housekeeping staff, 1 person to run the kitchen and the care workforce was down to less than a fifth of the usual staff, all because of Covid-19. My stomach lurched, no cleaner or laundry would mean that there was another duty for me to complete alongside an ever-increasing workload as the workforce depleted further. I tried calling agencies but there were no staff available. I think some agencies were also reluctant to send a Registered Nurse to the Home due to the outbreak of Covid-19 that we were experiencing. I realised that there was no other option but to live in the Home indefinitely. A bedroom of a former resident who had died was cleaned and I moved in. I stayed living and working in the Home for 10 days straight, committing to the 24/7 clinical care for around 20 residents with complex needs or Covid-19 and nearing the end of their lives. One resident had complex care needs including tracheostomy care and required regular suctioning and would ordinarily be nursed 1:1

but that just wasn't possible when I had up to19 other residents to look after. Usually there would be five or six nurses covering the week, now there was just me.

11. I remember sitting on the foot stool in the drug cupboard and calling my husband to tell him I wouldn't be coming home for an indefinite period. I was anticipating his protests. I had to be calm and clear. I tried to reassure him that I would be ok. I gave him a list of things I needed overnight, and he set out organizing what I would need. We had parted for days and weeks before this event, but this felt different. We had been forced apart. I didn't realise it at the time, but my senses were being starved of the familiarity and comfort of home.

12. I thought through worse case scenarios in my head. What would happen if I collapsed and there was no one to take over from me? I recall writing my final wishes on a card at 3am, in case I became unwell or incapacitated and there was no-one there to help me. I wrote a DNACPR and what I want to be dressed in if I should die; uniform and stole. I made sure to leave this card in a prominent place where it could be found.

13. I recall thinking that I was going to have to really prioritise care needs. I had a hotline to the GP to support me with medications and the same with a local hospice for help and advice with the care of the complex care resident. I knew that I would have to be organized and plan ahead when I was alert and attentive because there would be times where I would be operating on little to no sleep so I had to use my energy wisely when I had it. I drew strongly on my experience of being a mother to tiny babies who did not sleep. Babies have no concept of time and routine, and I applied that principle here. I needed to rest when I could and nurse when I could.

14. The residents were very distressed as they were isolating in their rooms. I would hear some of them crying and asking, "*where is everyone?*" It was hard to explain to them why we were having to take these precautions as many lacked capacity and were unable to communicate effectively.

15. The shifts felt like being a soldier on guard duty in the trenches. There was one resident next door to my room whom I would hear crying at night and another opposite, repeatedly shouted out for help. During periods of rising-anxiety I would hold-back the panic, retreating into the medicine cupboard to cry where no one could hear me. I realised I had to be strong and resilient for my residents, their loved-ones and staff.

They needed me to be present. My emotions lurched from stomach to chest, and I tried to keep anxiety sealed in a lead-lined box secured by chains deep inside of me.

16. When I retired to my room at night, I would take the monitor with me to bed to listen to the breathing of my complex-care patient so I could respond to any sounds. I ruled out trying to sleep in the same room, the bleeping sounds of equipment would have been too much. I was having to take little naps, in 30-minute snatches to keep a listening ear out for people. In between, I would check on residents with complex health needs, administer medicines to end-of-life patients, make preparations for morning drug rounds, and increasingly often, deal with death.

17. Eventually two carers were sent to us from a London Agency to live in the Home with me and provide support. It felt like such a relief. They were new to care work yet what they lacked in experience and clinical skills, was compensated by their loving service and devotion to human need. Amongst the crisis and amidst the complex decisions that we were having to make every day, the Home became an environment of nurture, of love and kindness.

18. Ensuring a loving, dignified death was my priority. It was a privilege to be alongside people at this significant point. I recall one occasion when I was living in the Home and I was alerted to a patient's deteriorating condition at 3am in the morning. I went to assess him in my nightie, having tried to get some sleep in the minutes before. I could see and hear Covid at work in the death-rattle (pulmonary congestion) and knew that the patient did not have much time left with us but whilst he might not have hours to live, I was going to make sure his death was dignified and peaceful. I gave him medication to ease his symptoms, and he died a few hours later. I verified his death and wrote up the paperwork. I returned to bed, conscious that I needed to reserve energy. The ritual of last offices would have to wait. My priority was to rest so that I could attend to the living and the dying on my next call. It is a decision that I shouldn't have had to make.

19. Something I had not experienced before was managing an unclaimed body if a family delayed providing permission for a funeral director to collect them. Surpassing twelve hours since death, I called the local authority for advice, they told me that this was a public health matter, and that the Environmental Health Agency would need to be notified. They supported me with liaising with the family, and that evening, a funeral director collected them.

20. Between the Winter of 2020 and January of 2021, the Home lost almost half of its residents and two members of staff due to Covid-19.

Availability and adequacy of PPE

21. PPE shortages earlier on caused significant stress. In I&S 2020, we called local businesses and universities for spares and staff in the Home even fashioned gowns from bedsheets in an attempt to prepare ourselves for the arrival of the virus. We felt woefully mistreated as a sector. We did not have a plentiful supply of PPE when it became compulsory to wear a mask. When we had lunch, we would seal our masks in a little freezer bag. The minute we finished eating, we would unzip the bag and put the mask back on because we didn't have enough stock to replace them with a clean, fresh mask.

22. We had training in donning and doffing PPE, as Infection Control Lead in both Homes I worked in, I took a lead role in audit and supervision for staff and visitors. By the end of January 2021, my face was raw with dermatitis from mask wearing and long hours in aprons left us wet with sweat.

23. We saw FFP3 masks being given to nurses in hospitals, but we were given surgical face masks. We were providing care in close proximity to residents and undertaking aerosol generating procedures for some of our residents with respiratory conditions. When I had to suction a resident, I would double-mask with a face shield when we had stock, to add an extra layer of protection. I also recall going to a DIY store to buy stock FFP1, the kind worn on building sites, as we felt that this would give us extra protection than the surgical masks, but we used them sparingly, as we did not have enough for everyone. FFP3 masks were obtained during Autumn-Winter of 2020, for our tracheostomy patient, for the aerosol-generation procedures as they required regular suctioning and nebulizing-therapy. I do not recall mask-fit testing I&S. Whilst fit testing didn't occur in the Home in I&S whilst I was there, this doesn't mean it didn't happen.

24. As time wore on, when external professionals visited the home, I was struck by the difference in the PPE they were wearing compared with what we had. Funeral directors would come to the door in their suit and tails and then would change into hazmat suits before entering. I was greeting them in a gown and a paper face mask. I suddenly felt

vulnerable, and I realized they were being protected from me. When the nursing home I&S became a 'hot zone' for infection, the hospice nurses wore suits akin to those worn for emergency chemical, biological, radiological and nuclear incidents, with full hood and non-powered respirators.

25. The impact of wearing face coverings was also difficult for our residents. They couldn't understand why we were now wearing something which covered most of our faces. It was alien to them and frightening. Sometimes you would have to unhook the ear loop and show them your face briefly behind the mask, so they could recognise who you were otherwise you would be dealing with very distressed residents whose behaviour was escalating, making it difficult to deliver essential personal-continence care. This would then impact on nursing resources further as it would take time to calm the residents and provide reassurance. It certainly impacted our relationships with the residents initially and we saw an increase in behaviours that challenge due to distress and disorientation, yet it is remarkable how adaptable people can be even with profound communication difficulties. We would draw smiling lips on our masks and learnt to smile with our eyes and communicate with our eyebrows.

26. I recall that there was inappropriate use of clinical gloves. Gloves only need to be donned at the 'point of care' after hand washing, and then removed immediately after care contact followed again by hand washing. This is a very well-researched evidence-based practice. Implementing this practice with visitors and sometimes staff was incredibly challenging because of all the new behaviours that the general public were adopting from ill-informed 'advice' and conspiracy theories.

27. There was constant handwashing and use of alcohol gel. Day and night, all the time. In the end my knuckles split and bled. I had hand cream at my bedside and in the office. There was never any let up.

Transfer of residents to hospital

28. Transferring some residents out to hospitals when they required emergency care was difficult. I remember calling for an ambulance for one patient who was developing urosepsis. In nursing home care we can do most things, but IV fluids and antibiotics are not within our remit. Registered Nurses are knowledge-intensive safety-critical decision makers, expert in our field of practice and know when to draw on additional resources for early treatment and prevention of illness. That said, we know that sepsis can be fatal and early intervention is key to saving lives. A category 2 999 call was

therefore arranged (which is for emergency situations that are serious but not life-threatening, requiring rapid assessment with an average response time of 18 minutes) but there were 14 other category 2 calls in the pipeline already and the available ambulance service was depleting. I was told that the hospital was an hour away from declaring a major incident because of Covid. The ambulance workforce had depleted by 30% which meant that there were only 2 or 3 ambulances available for the whole county. Covid was malevolently taking us out across the board. When the resident did eventually leave the home with the ambulance team, there was unsaid relief amongst the team – there was now one less life to worry about.

The impact of Track and Trace calls

29. Although I cannot now recall exact dates, there was a period when we were flooded with track and trace calls, enquiring about residents who had tested positive. I remember having to point out to those on the phone that every minute I spent talking to them meant that it was a minute in which I was not providing essential care to a resident and a minute more that they were neglected.

The impact of short staffing and moral distress

30. There were times when the team and I went through what I would describe as moral distress, when we could not provide the care that we wanted to due to lack of staffing. Not being able to meet people's needs became a matter of extreme anxiety and we worried about the fear of blame. I was so concerned about not being able to meet the requirements of my professional Nursing and Midwifery ("NMC") Code of Conduct, and fearful that I would inevitably be making mistakes, that I called the local authority safeguarding line and attempted to raise a safeguarding alert about myself. I knew what my NMC Code of Conduct expected of me and I knew I could not possibly achieve it all in the circumstances I was operating in. I carried with me a heavy legalistic responsibility. I pictured having a referral to my regulator which would haunt me for months or years to come. I worried that I could be scapegoated, blamed for things that could go wrong or care standards that could not be achieved. I was responsible for myself, for the staff and for the residents. I knew that I would do my best based on my conscience and ability. The buck stopped with me. I was exhausted and I was a risk. I felt that care standards were slipping, not intentionally but due to the lack of provision of staff resources, and the situation could worsen. I felt the need to be candid about this and it was my duty to speak out. I made a call to the safeguarding team. I explained

that we had run out of nursing staff and had spent days trying to obtain cover but to no avail. There were not enough carers to look after the residents properly. My manager was very ill and was trying to do the best he could from home whilst attempting to recover. I recall getting upset and crying down the phone and then gathering myself. The person I spoke to on the safeguarding hotline was very sympathetic and reassuring and told me that I couldn't safeguard myself, only others. I told them that I could make mistakes and omissions were inevitable. I was given reassurance. I was also contacted by them a few days later to check how I was coping. I was touched by that simple act of kindness.

Sickness pay for Care Sector staff

31. I vividly remember the announcement Boris Johnson made during one of his daily press conferences regarding sickness pay for healthcare staff. Instead of receiving statutory sick pay from day 5 of an illness, the payment would be made from day 1 if you met the necessary criteria including a positive Covid-19 lateral flow test. I thought this was a much-needed amendment and would enable people to feel that they could take the time they needed to recover from their illness, rather than struggling to come into work, conscious that for every day they did not do so they would be losing out on money. There was an unspoken pressure that they needed to return, to be paid, to be able to afford to live and to eat. There was also the guilt factor. People enter this profession because they care, both for the residents and their colleagues. They were keen to get back to relieve the pressure on their team and to be there for their residents when they needed them most.

32. I recall the announcement that social and residential care settings were being given ringfenced money by the state to enable infection prevention and control measures to be implemented in the social-care sector, to enable PPE stock to be purchased and to ensure that staff who were isolating due to Covid-19 absence, would still receive their normal wages so that they did not lose money due to being ill and having to be absent from work. Unfortunately, this ringfenced money was not received by my colleagues and I, not even for the mandatory 10 days isolation period. When we were absent from work due to Covid-19 we received only the statutory sickness payment and not our normal wages. I was incensed by this. How are we to retain experienced nurses and carers who are dedicated to caring for their residents, if the state allows them to be exposed to Covid-19 and then exposes them again to financial ruin when they attempt

to recover during their illness? I wrote to my MP at the time, and we had a telephone interview to discuss this. I challenged him to explain where taxpayers' money allocated to our local authority was when it was supposed to be ringfenced for social and residential care providers. The obvious impact was that people were returning to work when they were still unwell but who could not afford to be unpaid.

33. When staff started returning to work after isolating, they needed both physical support, as many were still recovering from Covid-19 and emotional support, due to the trauma of losing residents and family connections they'd had over preceding years and witnessing empty rooms and closed doors. I would get them in the office and give them a full debrief. I also gave them permission for extra breaks, for tears, to mourn, for conversation to stop and talk about things because they needed to be weaned back into their role.

My experience of Long Covid and Post Traumatic Stress Disorder

34. After four days of living in, I stopped taking daily Lateral Flow Tests. There seemed to be little point. If I had tested positive, there wasn't anything I could have done. No one else was coming to replace me. I ended up testing positive for Covid-19 at work on Saturday 16 January 2021. I left the Home and isolated in my own home for the requisite isolation period. When I returned to work two weeks later, I found that I was struggling with symptoms of Long Covid and Post Traumatic Stress Disorder ("PTSD"). I was subsequently signed off work for a month. I was having action replay of events or incidents that went on in the Home. My experience was a cross between an absolutely wonderful and rich human experience that I will never forget but an incredibly traumatic experience at the same time.

35. Since catching Covid-19, I came to dread the mornings when I would wake up feeling as if there was an elephant sitting on my chest. I experienced heart palpitations, breathlessness, fatigue and terrifying brain fog. It was worse when I returned to work, I would pray at sunrise for the Lord to be with me, daily anxiety became dread. I mourned for my brain, I felt disabled by brain fog and self-hypervigilance, I was double and triple-checking every single thing I did and every drug I administered.

36. During the May bank holiday in 2021 I was supposed to be on shift at the care home. Instead, I was being wheeled from an ambulance into the A&E department of the local hospital, still wearing my nurse's uniform. I had set off for work at 06:15am and by

10am my colleague was calling an ambulance for me. My symptoms had escalated plus there was a pain down my left arm which is the classic sign of a heart attack. I wondered whether Covid-19 was going to finish not only my career but also my life. Fortunately, I was sent for tests which ruled out a heart attack and instead pointed to me having Long Covid. I was discharged that evening.

37. The outcome of nursing during this wave of the virus left me with PTSD, the physical effects of anxiety and exacerbating my Long Covid symptoms and vice versa. I would experience random palpitations, and it would suddenly stop me in my tracks. I hadn't accounted for the process of psychological decompression from such an intensive environment and powerful co-dependency with colleagues. I was leaving this community whilst entering a new kind of isolation at home, sleeping in a separate room from my husband and partially isolated from family to protect them.

38. When I returned to work part-time after contracting Covid-19, I put on a brand of mask with a distinctive smell and was teleported back in time to living in the Home. It was so difficult to process. I sought support from my faith community, my family and other nurse colleagues and decided to reduce my hours. Yet returning to the scene of distressing memories repeatedly had a lasting impact. I was finding it difficult to get past the ghosts in the care home. I'd go into a room where I had previously provided long intense hours of difficult nursing care and there would be a different occupant in the room. Life was moving on but I wasn't able to.

39. My acute PTSD stage has now passed but the memories I have are there for life and the images in my mind can be quite raw. I have been around death and dying for years, end of life care was my specialism, and I was incredibly passionate about it but this was raw because of the intensity of death and having so many residents die in such a short period of time. Yet, living in and amongst the people in this way has been an enormous privilege.

40. I ultimately took the tough decision to resign from nursing home nursing in June 2021 and later took a part-time job working in prison health. I made the decision to go part-time as I wanted nursing to continue to be a part of me, not to destroy me. In October 2023 I gave up my nursing PIN. The heart attack scare confirmed my decision to step back after a total of 17 years in the profession. Despite initially being determined to power through it, I found that I wasn't able to, and I needed time to recover. After my experience in January of 2021, of living in the Home, I took some counselling through

the NHS and maintained vital support from my Queen's Nurse colleagues and my minister who was married to a Registered Nurse.

41. In 2018 I started the discernment process for ordained ministry. In 2019 I trained to be a Healthcare Chaplain through a London teaching Hospital on a part time course through London South Bank University. In April 2021 I was interviewed by the Bishop of Portsmouth by video-call in the nursing home's medicines cupboard. After a Bishop's Panel three months later, I was accepted into theological college, a three-year part-time course alongside part time work in nursing. I commenced this course in Autumn 2021 which led me to ordination in June 2024 in Portsmouth Cathedral. Even from my initial nurse training, I had always felt directed towards spiritual care.

42. Five years on, I carry some 'experiential scarring', but I believe that Covid-19 shaped a crucial time in I&S nursing home and the period of living-in, has transformed and refined the person I am today. Boxing Day carries an annual reminder of how we felt when the I&S was recategorised from tier 1 to 4 risk measures. Each January can also be an emotive month, but I know that I am one of the lucky ones. I truly handed myself over to the Lord our God and felt His tangible presence with me throughout. When things were beginning to seem impossible something or somebody would simply show up. Looking back, I see how the struggle has shaped the joy I have now.

Observations and recommendations

43. In the course of writing this statement, I have reflected on what I thought went well during the pandemic and what could be improved to ensure that the Care Sector is resilient to any future pandemics:

   i) The Care Sector has always been responsive to infection outbreaks, notably Norovirus. As a consequence, infection control practice to isolate and manage visiting was always in the nursing toolkit, just not on the scale that COVID-19 brought.

   ii) Before the COVID-19 pandemic, our global neighbours had experiences of coronaviruses such as Severe Acute Respiratory Syndrome (SARS-CoV) Middle East respiratory syndrome coronavirus (MERS-CoV), Influenza pandemic 'swine-flu' 2009, H1N1 virus, also 1918-1920 H1N1 'Spanish flu' post WWI. MPs for health in the UK must collaborate with global governments in monitoring trends in viral behaviour and learn from our global neighbours in the prevention and management of outbreaks. Viruses such as H1N1, SARS, MERS for example served as warning shots to which I feel the UK has been unresponsive. Lockdowns were delayed. Human-behaviour to panic-buy and to hoard must be anticipated and managed early to ensure accessibility for all.

iii) Training and resources must be proportional to present-day risk in the Care Sector. I often ask, what occurs with more frequency and intensity in nursing and residential homes - fire, moving and handling or transmissible infection outbreaks?

iv) Extending my above example to other providers with large work forces in allied public service roles and to private sector employers - it would assist to embed infection prevention and control skills in the collective societal conscience in order to give it the same prominence (if not more) than that given to fire safety/evacuation procedures. All staff undergo manual handling and fire safety training. Should equal consideration not also be given to training on basic infection, prevention and control procedures?

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 30 April 2025