

Wednesday, 8 October 2025

1  
2 (9.59 am)  
3 **MS CAREY:** My Lady, good morning. I hope you can see and  
4 hear me all right?  
5 **LADY HALLETT:** I can, Ms Carey. Good morning.  
6 **MS CAREY:** Thank you.  
7 This morning we're going to deal with two witnesses  
8 dealing with the impact of the pandemic on healthcare  
9 and the provision for children and young people. And  
10 can I ask, please, that Mr Duncan Burton is sworn.  
11 **MR DUNCAN BURTON (affirmed)**  
12 **Questions from COUNSEL TO THE INQUIRY**  
13 **MS CAREY:** Mr Burton, good morning.  
14 **A.** Good morning.  
15 **Q.** Your full name, please.  
16 **A.** Duncan Alasdair Burton.  
17 **Q.** You have, on behalf of NHS England, provided the Inquiry  
18 with a very comprehensive, over 250-page statement on  
19 behalf of NHS England. And I think you are here this  
20 morning in your capacity as the Chief Nursing Officer  
21 for NHSE, as I'll call it for short.  
22 **A.** That's correct.  
23 **Q.** You set out that you've been a nurse since  
24 September 1998, held a number of positions since then,  
25 and, indeed, are a member of the Royal College

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1 statement that you held the executive responsibility for  
2 children and young people, but what does that actually  
3 mean in practice, Mr Burton?  
4 **A.** Yes, so, as executive lead, I'm not responsible for  
5 every element of children's care throughout NHS England.  
6 So, for example, mental health care for children and  
7 young people would be the responsibility of the  
8 executive that's responsible for mental health, but  
9 as -- within my role I have a number of different  
10 responsibilities for children, so the Children and Young  
11 People's Transformation Programme, which is very much  
12 focused on making improvements for care for children,  
13 so, for example, around epilepsy or asthma or the  
14 rollout of the national early warning scoring system for  
15 identifying critically ill children at risk of  
16 deterioration.  
17 The other thing, then, I'm responsible for is  
18 actually the Children and Young People's Transformation  
19 board, which brings together, across NHS England, all of  
20 the kind of elements that people are working on in  
21 relation to children and young people, be that through,  
22 kind of, the Learning Disabilities Programme or the  
23 Mental Health Programme.  
24 We've also got representation there from the  
25 Department for Education, the Department of Health and

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1 of Nursing.  
2 **A.** That's correct.  
3 **Q.** You, during the pandemic, from September 2019 to  
4 April 2021, were the Regional Chief Nurse for the south  
5 east of England, and I think since July 2024 you've been  
6 the Chief Nursing Officer for England, taking over from  
7 Dame Ruth May.  
8 **A.** That's correct, yes.  
9 **Q.** All right. I would just like, briefly, to ask you,  
10 please, to explain the role of the Chief Nursing  
11 Officer, particularly with emphasis on how it relates to  
12 children and young people.  
13 **A.** Yes, absolutely.  
14 So, the Chief Nursing Officer for England has  
15 several different roles, one of which is the most senior  
16 adviser on nursing and midwifery matters to government  
17 and the Department of Health and Social Care. And also,  
18 then, as an executive member of NHS England, have  
19 a range of responsibilities across a number of different  
20 portfolios. For example, particularly relevant to  
21 children and young people is the executive lead for  
22 children and young people, the Children and Young  
23 People's Transformation Programme, maternity and  
24 neonatal care.  
25 **Q.** Can I ask you about that, because you say in your

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1 Social Care, and partners such as the Royal College  
2 of Paediatrics and Child Health.  
3 So, one of my key roles is actually about how do we  
4 give voice for children and young people and make sure  
5 that the voice of children and young people is really  
6 strong in the work that we do. And one of the great  
7 things in that transformation board is we have young  
8 people who are members of that, supported by a youth  
9 forum.  
10 And that continued throughout the pandemic as well.  
11 **Q.** That's what I was going to ask you.  
12 And if I may interrupt you, Mr Burton, obviously  
13 you've got a very wide remit, a number of which doesn't  
14 cover the impact, necessarily, of the -- or not  
15 necessarily the direct impact of the pandemic on  
16 children, but I would like to focus your answers,  
17 please, on pandemic issues, whether they're  
18 pre-pandemic, during, or indeed post-pandemic.  
19 Just help us, then, with the young people on the  
20 board during the pandemic. Did they meet often? What  
21 kind of input did they have? Can you give us some  
22 examples of how they actually positively made  
23 a difference to NHSE's response.  
24 **A.** Absolutely. So -- well, first of all, I'll just say how  
25 grateful I am to the young people that contributed and

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1 continued throughout the pandemic to help give their  
2 voice to how things were. So one of the reflections  
3 from the team, particularly about the work that they  
4 did, was feed in actually how it was feeling for them at  
5 the time, and we made sure that we tailored the way in  
6 which they interacted, so it was online, make sure we  
7 had that wraparound support for them to continue to  
8 participate in the work that we were doing.

9 But that also enabled us, and the team, to be able  
10 to understand what we might need to be focused on in the  
11 pandemic and our response to that.

12 So they met, the Young People Transformation  
13 Programme Board met frequently, I think met on 2 April,  
14 so right in the middle of 2020 in the pandemic and  
15 looked at a number of the areas around the impacts of  
16 the pandemic, in the here and now, and potentially in  
17 the future for children and young people.

18 **Q.** Did that include not only the mental health impact but  
19 impact on actual medical conditions or was it more  
20 focused on the mental health impact on children?

21 **A.** It was all of the impacts that were taking place at that  
22 time.

23 **Q.** All right. We may touch on the engagement with children  
24 and young people as we go through your evidence this  
25 morning, Mr Burton, but can I take you back, please, to

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1 **Q.** -- remote appointments and the like for non-direct care,  
2 and plan for stopping elective procedures and  
3 treatments, especially those that may consume critical  
4 care and ward resources.

5 Now, can I ask you about that last subparagraph  
6 because people might be wondering why you were  
7 potentially stopping elective procedures that might  
8 consume critical care because it might suggest that the  
9 treatment was urgently needed albeit that it also might  
10 have a significant impact on the child or young person.  
11 Why was that part of NHS England's advice to  
12 paediatricians?

13 **A.** So I think if you go back to the period of time in  
14 March 2020 and we were faced with an overwhelmingly  
15 significant risk of a huge amount of critical care  
16 capacity being needed for dealing with Covid-19, which  
17 was unprecedented. Clearly we had to respond to that,  
18 and I think what this shows is particularly we were  
19 thinking about all parts of the system and actually how  
20 it could all contribute to that significant effort of  
21 caring for people with Covid-19.

22 I think, if you look later at the -- or the phase I  
23 letter on the next day, I mean, clearly, there is -- at  
24 no point do we stop or suggest we should stop anything  
25 that was urgent that wasn't Covid-19, but we also knew

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1 March 2020, and I'd like to examine with you some of the  
2 decisions taken to free up capacity for Covid-19  
3 patients, primarily to free up capacity for adult  
4 patients, but look at the impact of that on the  
5 provision of healthcare on children and young people.  
6 I think, as you told us, you, at the time, were the  
7 Regional Chief Nurse for south east England, so not  
8 exactly a small region.

9 And can we go, please, to your paragraph 252, and  
10 16 March 2020, where NHSE published its first iteration  
11 of the Clinical guide for the management of paediatric  
12 patients during the coronavirus pandemic.

13 **A.** Yeah.

14 **Q.** And just to help your Ladyship, the next day, came out  
15 the phase I letter which essentially was designed to  
16 free up a number -- thousands of beds by the cessation  
17 of elective care, by increasing private healthcare  
18 capacity, and expediting discharges with which I know  
19 your Ladyship will be familiar.

20 But that's where we are in the timeline.

21 And we can see there that NHS England advised  
22 paediatric services to keep children out of the  
23 healthcare system unless essential; use telemedicine --  
24 do you mean remote?

25 **A.** Yes.

6

1 at this point in time that the risk to children, it was  
2 emerging that the risk to children of Covid-19 was, in  
3 comparison to adults, less on critical care resources,  
4 and impact. That is not in any way to lessen the impact  
5 that it did have on some children and sadly some  
6 children did lose their lives to Covid-19 and I don't  
7 want to lessen that impact at all, but comparatively to  
8 adults, it was different.

9 So we therefore needed, you know, to make sure we  
10 were freeing up resource to be able to have sufficient  
11 critical care capacity and some of that included the  
12 response from our paediatric colleagues in places such  
13 as paediatric intensive care.

14 **Q.** Right. I think also the letter set out the possibility  
15 of redeployment for students newly qualified and even  
16 some junior paediatric staff to adult services. So that  
17 brings us on to that phase I letter, and as we know, it  
18 was considered vital to free up, I think it's between --  
19 up to 30,000 beds across a number of measures taken  
20 during that month, but in particular, by pausing  
21 non-urgent services, it was hoped that that could free  
22 up 12,000 to 15,000 beds by that measure alone.

23 Just can I ask you about the letter that was sent  
24 out to all the trusts and the various other  
25 organisations involved. Do you agree, Mr Burton, that

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1 there was no specific reference in that 17 March letter  
 2 to children and young people explicitly?  
 3 **A.** There wasn't a specific -- it was all-age.  
 4 **Q.** Right.  
 5 **A.** And obviously we'd issued the guidance the day before,  
 6 which you've just displayed on the screen.  
 7 **Q.** All right. But I take it that by pausing elective care,  
 8 or planned care, to call it another phrase, that  
 9 implicitly included services for children and young  
 10 people?  
 11 **A.** Absolutely.  
 12 **Q.** And you say in your statement that in England, patients  
 13 including children and young people should not normally  
 14 wait longer than 18 weeks to start elective treatment  
 15 once they've been referred by a consultant; is that  
 16 right?  
 17 **A.** That's correct.  
 18 **Q.** So does it follow that it was obvious that in pausing  
 19 elective care, it was likely that 18-week target was not  
 20 going to be met in a large number of cases, whether  
 21 adult or children and young people?  
 22 **A.** I absolutely think that's right, yeah.  
 23 **Q.** Right. As at 17 March, can you help, was there any idea  
 24 about when elective treatment may be able to resume or  
 25 was it not possible to say as at the 16th, 17th?

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1 Nurse, we were very much focused on the here and now,  
 2 because that's what all of the energy and time needed to  
 3 be on.  
 4 **Q.** All right. There was, however, a plan a few weeks later  
 5 that was announced in the phase II letter on 29 April of  
 6 2020, and it was a plan to really establish how  
 7 NHS England was going to operate now that patient  
 8 numbers were beginning to fall, although it was clear  
 9 that Covid was not going away. Can I ask you, please,  
 10 about some aspects of the phase II letter.

11 And could we have on screen INQ000087412.

12 And there's the letter on 29 April, and page 5,  
 13 please.

14 If we look at the top of the page, the letter from  
 15 Sir Simon Stevens, as he now is, and indeed Amanda  
 16 Pritchard, made it clear to the recipients of the letter  
 17 that:

18 "Over the next six weeks and beyond we have the  
 19 opportunity to begin to release and redeploy some of the  
 20 treatment capacity ...

21 "... [it] means we are now asking all NHS local  
 22 systems and organisations working with regional  
 23 colleagues to step up non-Covid urgent services as soon  
 24 as possible ..."

25 And they also ask that within the regional teams,

11

1 **A.** I think on the 16th and 17th, if I go back to my time as  
 2 the Regional Chief Nurse there, we were in the midst of  
 3 dealing with, at pace, a significant challenge around  
 4 how do we make sure that there's sufficient critical  
 5 care capacity for the wave of Covid that was coming, and  
 6 therefore, you know, I think whilst we continued to make  
 7 sure, and be very clear in our communications about the  
 8 need for the most urgent of elective cases, or emergency  
 9 cases to continue, we had to focus our energy and effort  
 10 on that.

11 So at that point in time I think it's fair to say we  
 12 were very much in the midst of focusing on that.

13 **Q.** So there was -- for the reasons you've set out, no  
 14 ability to say, "Well, we're going to be able to start  
 15 it four, six, eight, 12 weeks", but was there in fact  
 16 a plan as at 17 March, or thereabouts, for how  
 17 resumption would start? Even if you didn't know when?

18 **A.** I'm not sure I'm able to answer. I don't believe that  
 19 there was a specific plan although what I would say, as  
 20 part of any of our EPRR processes, there are -- sorry,  
 21 our emergency response processes -- there's always  
 22 a look about how do we do recovery. But at that point  
 23 in time, and my recollection of that point in time,  
 24 particularly, kind of, if I -- I was a member of the  
 25 gold leadership team in the region of the Regional Chief

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1 for those teams "to make judgements on whether you have  
 2 further capacity for at least some routine non-urgent  
 3 elective care".

4 And attached to the phase II letter was an annex  
 5 which did in fact make reference to some children and  
 6 young people's services and if we look, for example, at  
 7 page 7 of the annex, we can see there particular  
 8 reference to maternity care, both antenatal and  
 9 postnatal care, looking both, obviously, to reassure the  
 10 women but also to care for the babies that have arrived.

11 And if we go on, please, to page 8, there is  
 12 reference there to community services and the bottom  
 13 bullet point:

14 "Essential community health services must continue  
 15 to be provided, with other services phased back wherever  
 16 local capacity is available. Prioritise home visits  
 17 where there is a child safeguarding concern."

18 Now, may I ask you about that. Clearly, there was,  
 19 on 17 March, the advice to stop community health  
 20 services, which would have had an impact on safeguarding  
 21 concerns, but do you know, Mr Burton, did all home  
 22 visits, where there was a safeguarding concern, stop or  
 23 was there able to have some between 17 March and now the  
 24 end of April?

25 **A.** Yeah. So I think just in terms of this letter you --

12

1 sorry, did you say 17 March?

2 **Q.** Yes.

3 **A.** Yes, so I think on 17 March clearly there was the letter  
4 that had gone out. On 19 March there was guidance that  
5 was -- additional guidance that was sent out in relation  
6 to community health services, which set out actually,  
7 a table which I think is part of the evidence pack.

8 **Q.** Well, if you want me to go to it now to help you, let me  
9 slot it in now, and can we have up on screen, please,  
10 INQ000049706, which I think might help you, Mr Burton,  
11 with the position in relation to community health  
12 services.

13 So let's just backtrack slightly so it's clear in  
14 the timeline. 17 March, the exhortation to suspend all  
15 elective, non-urgent services, including community  
16 health services but a few days later, within community  
17 health services, there was a letter that was sent out  
18 prioritising some community health services, and if we  
19 go, please, to page 2, I hope we will have there --  
20 there we are -- the guidance that accompanied it, about  
21 what should be stop -- what should be partially stopped,  
22 forgive me, and what should continue.

23 And we can see there in red there was a decision  
24 taken to stop National Child Measurement Programme,  
25 Audiology, and the Friends and Family Test.

13

1 Audiology, and the Friends and Family Test. We can see  
2 vision screening, a partial stop, say, for newborns, and  
3 the six weeks check. And if we just go to page 2 you  
4 can see then there are various stops but with the  
5 "Exception" column --

6 **A.** Yes.

7 **Q.** -- the pre-birth, school nursing, community paediatric  
8 service was continued, and if we go on, please, to  
9 page 5, in the "Continue" section, safeguarding is said  
10 to continue.

11 Do you know whether that was done in person, online,  
12 or how it was envisaged that safeguarding community  
13 health services would continue for children and young  
14 people?

15 **A.** Yes, and if I can just go to the safeguarding section of  
16 my statement, if that is okay.

17 **Q.** Certainly.

18 **A.** I'll just find that. I think the thing to just reflect  
19 on as well is that at this point in time, if you  
20 remember, about the 17th, we were also dealing with  
21 a new virus, where we were trying to make sure that we  
22 were protecting staff as well as patients in some of  
23 this decision making.

24 In terms of safeguarding, NHS England's  
25 responsibility for safeguarding did not change

15

1 What was the rationale or the basis for deciding  
2 what to stop, what to partially stop, and what to  
3 continue?

4 **A.** Yeah. So I think if we go back to the letter of the  
5 17th, that clearly went to everybody, set a very  
6 clear -- what the health service needed to do respond to  
7 the pandemic immediately. Clearly, this subsequent  
8 guidance was around clarifying and making sure it was  
9 clear for community health services, and supporting that  
10 local decision making, around what areas could be  
11 stopped and what areas needed to be kind of managed on  
12 a risk basis, and you'll see as you go through this  
13 document, not everything was stopped. Some of this was  
14 suggested about what could go on to -- online, for  
15 example; what needed to continue, particularly if you  
16 look at some of the services around those most  
17 vulnerable children, looked after children,  
18 safeguarding, for example.

19 So this was really to help and support those  
20 community services with understanding what that stop of  
21 non-urgent work needed to be.

22 **Q.** All right. So we can see there they stopped some  
23 programmes, presumably although preferable for them to  
24 continue, it wasn't sort of clinically necessary to  
25 continue the National Child Measurement Programme,

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1 throughout the pandemic, and in fact what our  
2 safeguarding teams did was to make sure that we  
3 pivoted -- or made sure that we kind of reacted to the  
4 needs of children and young people in terms of  
5 safeguarding. So, for example, one of the things that  
6 was coming out very early around this period was that  
7 there were a number of looked-after children that were  
8 having to relocate around the country. So, you know, we  
9 asked for a COPI notice to make sure we were able to  
10 share information and data with other parts of the  
11 system to make sure we were responding to what we were  
12 seeing in terms of safeguarding needs.

13 But, you know, our responsibilities as professionals  
14 didn't change during this period of time for  
15 safeguarding.

16 **Q.** Right. Your responsibilities may not have changed but  
17 do you know if actual safeguarding visits took place in  
18 person, or did they move to online, or was there  
19 a hybrid system? Do you know the position?

20 **A.** So, I think in terms of safeguarding, when we say  
21 safeguarding visits, there are a number of different  
22 professionals that have -- well, every professional has  
23 a responsibility around safeguarding. Clearly, there  
24 were -- there are professionals that have responsibility  
25 for -- well, all are responsible for safeguarding but

16

1 some have responsibility for identifying needs,  
2 et cetera -- so, for example, health visitors -- during  
3 this period. And you'll see in this document, for  
4 example, health visiting, there was suggestions about  
5 some of that moving online, some of that stopping, and  
6 some of it very much focused on those children most at  
7 risk.

8 So I think it's fair to say safeguarding activity  
9 didn't stop, but safeguarding activity had to change to  
10 keep up with this. So, for example, you know, as  
11 testing centres came on, we made sure that the staff in  
12 testing centres were trained around safeguarding and  
13 what the things they might need to look for and spot in  
14 some of these areas. And then we also, as more clinical  
15 contacts happened online, we needed to make sure that  
16 the kind of guidance around online factored in the  
17 safeguarding needs of children.

18 **Q.** Were you, in relation to these decisions that we've been  
19 looking at, either to stop, continue or somewhere in the  
20 middle ground, do you know whether the basis for  
21 deciding what to stop and what to continue was taken  
22 from a health perspective, a cost perspective, a staff  
23 redeployment perspective, all of those things and  
24 others? Do you know what the basis was for these  
25 decisions?

17

1 focus was on returning to what they called "near normal"  
2 levels for non-Covid health services, and to try to  
3 maintain routine elective surgery, and prepare for  
4 wave 2 and/or the winter. And we know there were  
5 a number of targets set.

6 There's just one aspect of the phase III I'd like to  
7 ask you about, please.

8 And could I have on screen INQ000045147.

9 And it's reference to, in the letter -- page 6,  
10 please -- to expanding mental health services.

11 Her Ladyship has heard in other modules about the  
12 increase in demand for mental health services as  
13 a result of the pandemic, and here we are, at the end of  
14 July, with NHS England asking for there to be an  
15 expansion and an improvement in mental health services  
16 for people with learning disability and/or autism,  
17 including, within this, specific reference to children  
18 and young people.

19 If we look just down to the middle bullet point,  
20 there's reference there to asking systems to validate --  
21 I think it's their long-term priorities for mental  
22 health services expansion, improving access to --  
23 I think it's psychological therapies:

24 "- IAPT services should fully resume.

25 "- the 24/7 crisis helpline ..."

19

1 **A.** Well, I think I would -- I would put cost to one side.  
2 I don't think cost ever at this point in time entered  
3 into the -- certainly into the conversations I was in or  
4 any of the decision making in terms of -- that was made  
5 at NHS England. I think the decision making that was  
6 taking place at that time -- actually, could you repeat  
7 the question, please.  
8 **Q.** Well, really, was it taken on the basis of clinical need  
9 or was it taken "We'll stop that because actually that  
10 would free up 100 staff"?  
11 **A.** Yeah, so it was based on all of those factors. So  
12 essentially we had -- you know, we had to provide staff  
13 to staff critical care services that wave of the  
14 pandemic. So we needed to free up staff. We also  
15 needed to protect staff, so actually we wanted to make  
16 sure that we were -- and patients -- wanted to make sure  
17 that the contacts that needed to be had were the most  
18 essential contacts, but also thinking about the needs of  
19 most vulnerable children.  
20 **Q.** Right. We're going to look at some of the impacts on  
21 children in a moment. But just to deal with the final  
22 phase III letter, so there was a plan for some  
23 resumption by the end of April 2020, and then, come  
24 31 July 2020, NHS England set out the priorities for the  
25 remainder of that year, and specifically stated that the

18

1 Should continue.

2 And:

3 "- maintain the growth in the number of children and  
4 young people accessing care.

5 "- proactively [reviewing] ... patients ...

6 "- [ensuring] ... local access ... is ...

7 advertised."

8 And:

9 "- [using] £250 million of ... new capital to ...

10 eliminate mental health dormitory wards."

11 Are they anything to do with children and young  
12 people, Mr Burton, that last bullet?

13 **A.** I would have to come back to you on that one.

14 **Q.** All right. And then clearly work being done, in the  
15 next bullet point down, to support people with learning  
16 disabilities, autism or both:

17 "- [continuing] to reduce the number of children,  
18 young people and adults within a specialist inpatient  
19 setting by providing better alternatives ..."

20 And:

21 "- [completing] ... [the] Learning Disability

22 Mortality Reviews ... by December 2020."

23 Do you know whether this was designed to cope with  
24 people who were already in the system, who had mental  
25 health difficulties, and/or to cope with the new people

20

1 that were coming forward, children and young people in  
 2 particular, who had mental health difficulties, or a bit  
 3 of both?  
 4 **A.** A bit of both.  
 5 **Q.** All right.  
 6 **A.** And I think just, you know, the reason, you know, kind  
 7 of maintain the growth was because, you know, there was  
 8 already work happening before the pandemic to scale up  
 9 services for children and young people's mental health,  
 10 and in some ways the pandemic accelerated the need for  
 11 that.  
 12 And I think, you know, to go back to hearing the  
 13 voice of children and young people, certainly we were  
 14 hearing directly from children and young people about  
 15 concerns around mental health, and I know the mental  
 16 health and learning disabilities team heard the same  
 17 through their connections and routes and working with  
 18 organisations.  
 19 **Q.** Can I ask you about that. I think the Inquiry provided  
 20 you with extracts from the Children and Young People's  
 21 Voices report that the Inquiry commissioned, and clearly  
 22 in there, there's reference to the impact on children  
 23 waiting long times for mental health assessments and the  
 24 like. Is there anything in that report that surprises  
 25 you or does it resonate with what children and young

21

1 **Q.** Yes. Now, we're going look at other reasons for various  
 2 declines, but you say at your paragraph 270 that in  
 3 April 2020, there were 29,500 fewer planned hospital  
 4 admissions when compared with the year before, so nearly  
 5 30,000 fewer planned hospital -- and was that a direct  
 6 result of the phase I letter and the suspension and  
 7 pausing of elective care?  
 8 **A.** Yes.  
 9 **Q.** All right. And I think, just to show that in real  
 10 terms, can we have up on screen, please, page 92 of  
 11 Mr Burton's statement.  
 12 And a graph here that shows that, for under 18s,  
 13 elective inpatient admissions dropped off significantly,  
 14 we can see if we look at the blue shading, from  
 15 somewhere in and around the region of about 50,000  
 16 in 2018, 2019, and then if you look at the steep decline  
 17 in and around March and April 2020, helpfully  
 18 highlighted there, a real drop off. And then a slow  
 19 resumption in elective inpatient admissions, climbing  
 20 thereafter to almost, by January, 2024, back to roughly  
 21 where it was pre-pandemic.  
 22 Now, you said in your statement that in particular  
 23 there was -- a large proportion of the backlog comprised  
 24 treatments which were "age-critical in terms of  
 25 a child's development". What did you mean by

23

1 people were telling you in the transformation programme?  
 2 **A.** Yeah, I mean, when I read that it certainly resonated  
 3 with what we were being told, what we heard. And  
 4 I think it really brings into light the really wide  
 5 impact of this pandemic on children and young people,  
 6 not just mental health but physical health and other  
 7 concerns.  
 8 So I think, actually, this is why this Inquiry is  
 9 really important, particularly for children and young  
 10 people.  
 11 **Q.** All right. I'd like to just look at some of the  
 12 specific impacts with you, and in particular, starting  
 13 with hospital care. It's your section E, Mr Burton.  
 14 But I think you made the point that there was no  
 15 change to be -- or there was no advice to change the way  
 16 carers provided for emergency admissions; is that  
 17 correct?  
 18 **A.** That's correct, yes.  
 19 **Q.** But in fact there was a decline in emergency admissions,  
 20 both, in fact, for adults and indeed children and young  
 21 people, presumably in part because we were all going out  
 22 less and so there were fewer accidents and a fewer need  
 23 to call upon emergency?  
 24 **A.** Yes, I think that's one of the reasons that  
 25 -- (overspeaking) --

22

1 "age-critical"?  
 2 **A.** Well, I think one of the factors, when we look at care  
 3 for children and young people, is the needs of children  
 4 and young people, so for example, a child waiting for  
 5 surgery, it may be a significant proportion of their  
 6 life that they've been waiting. That has implications  
 7 for school attendance, it has implications for social  
 8 interactions with other children and the importance of  
 9 play, and then that kind of impact, therefore, on their  
 10 development through their childhood. So, you know, this  
 11 is why it's really important, clearly, that the impact  
 12 of waiting in some ways is different than for, perhaps,  
 13 an older person waiting. There are different dynamics  
 14 there.  
 15 **Q.** So it's not just the impact on their physical health but  
 16 on their --  
 17 **A.** Yes.  
 18 **Q.** -- developmental progress. I understand.  
 19 Now, one may understand why there was the need to  
 20 pause elective surgeries in the way you've explained but  
 21 perhaps, more importantly, is how it was recovered  
 22 thereafter, and can I ask you about that, please,  
 23 because you say in your statement at paragraph 279 that  
 24 there was a slower recovery of elective care for  
 25 children and young people. And in fact, by

24

1 November 2021, there were over 63,000 children waiting  
 2 for an inpatient procedure, nearly 6,000 of which were  
 3 waiting for dental procedures, 6,000 for specialised  
 4 surgery, 7,300 for trauma and orthopaedic surgery, and  
 5 35,000 waiting for general surgical procedures.  
 6 Would -- we think -- is that tonsillectomies, would that  
 7 be in the general surgery camp?  
 8 **A.** Yeah, it could be one of the things.  
 9 **Q.** All right. So there's 63,000-odd children waiting for  
 10 an inpatient procedure by November 2021 and I think,  
 11 generally speaking, NHS England accepts that recovery of  
 12 children's elective surgeries was slower than -- slower  
 13 for children than it was for adults; is that correct?  
 14 **A.** That's correct, yes.  
 15 **Q.** Now, can you help why was it the position that the  
 16 recovery of elective services is slower for children  
 17 than it was for adults?  
 18 **A.** Yeah. Well, I think there are a number of reasons, and  
 19 I think also just to be clear that we started to collect  
 20 data on this, or on the difference between -- or  
 21 disaggregate the elective and non-elective information  
 22 by age, which meant that from that period of time we  
 23 could start to see the difference in recovery for  
 24 children and young people. So I think that was an  
 25 important step, actually, in terms of being able to

25

1 **Q.** So shouldn't it be easier to get through the backlog for  
 2 children rather than the adult backlog?  
 3 **A.** Well, except children's services -- so, on children's  
 4 services, they're done in more specialist units often,  
 5 and so that was something that we were seeing happen  
 6 before the pandemic, we'd seen a shift of some of the  
 7 elective care into more specialist children's hospitals,  
 8 which, I think just to remind people, during this period  
 9 of time, children's services were equally impacted and  
 10 having to provide support to adult services.  
 11 So for example, paediatric intensive care staff and  
 12 paediatric intensive care capacity had been given over  
 13 to adults. We had staff that were supporting that. We  
 14 have a smaller workforce in children and young people as  
 15 well, who, you know, suffered the same things in terms  
 16 of sickness absence.  
 17 So when we've got smaller waiting lists, and there  
 18 is super specialist care on there that has an impact, if  
 19 we haven't got the intensive care capacity, the theatre  
 20 capacity, the anaesthetics. But I think -- look, it's  
 21 reasonable to say that there was a difference in the  
 22 recovery period as well, and there was investment that  
 23 was put in at the time and decisions that were taken  
 24 around investment which may have benefited, so to help  
 25 support the elective recovery, that may have benefited

27

1 identify that there was an issue.  
 2 There are a number of different reasons as to why  
 3 that was. And you will see within my statement, you  
 4 know, a number of pieces of work that were done to try  
 5 and support children and young people and the elective  
 6 recovery of children and young people, but clearly,  
 7 there was a significant backlog across all ages,  
 8 including adults, and some of the longest waits were  
 9 within adult services as well, and so there were  
 10 a number of different pieces of work that were done to  
 11 try and bring that together.  
 12 **Q.** I understand, and your statement sets out the pieces of  
 13 work but I think the real question I wanted to try and  
 14 understand was why is it that the recovery for children  
 15 was slower than it was for adults?  
 16 **A.** Yeah.  
 17 **Q.** And maybe it's not that there's one reason but can you  
 18 help us with why?  
 19 **A.** Yeah, if you just bear with me one moment.  
 20 So I think if you go to my statement on page 88,  
 21 paragraph 302, that sets out number of the kind of key  
 22 areas why there is potentially a disparity. Clearly the  
 23 waiting list sizes are different, between --  
 24 **Q.** But aren't they smaller for children?  
 25 **A.** They are smaller.

26

1 adults more than children and that might have been  
 2 because of some of the high volumes that there were  
 3 within adults. That's not to say that there wasn't  
 4 investment put in to help support children and young  
 5 people, for example in 2021 there was an investment into  
 6 the children's -- some of the specialist children's  
 7 hospitals of about £20 million to help support some of  
 8 the elective recovery of children and young people, but  
 9 I think it's reasonable to say there was a multitude of  
 10 reasons here, and also, because we've got data now,  
 11 I guess to the extent that that was happening before the  
 12 pandemic, I guess, is a slightly  
 13 unknown -- (overspeaking) --  
 14 **Q.** Yes. You make that point, I think that at 302  
 15 subparagraph (c), there was perhaps a lack of  
 16 visibility. It wasn't that there was no data, but can  
 17 I ask you about subparagraph (d) though, because the  
 18 disparity may have been due to:  
 19 "children's procedures being seen as less of  
 20 a priority compared to, for example, adult cancer  
 21 treatment."  
 22 Are you able to help, Mr Burton, by whom was it seen  
 23 as less of a majority? NHS England? Government?  
 24 Department of Health? Society?  
 25 **A.** I think I'd find that very difficult to answer. I would

28

1 say it's probably a mixture of the reasons that were  
2 taken to prioritise elements of certain elective care  
3 were taken at all different levels. So if I think about  
4 some of the decisions around the investment in elective  
5 recovery, there was funds that were made available to  
6 organisations and to trusts to be able to access. Some  
7 of those decisions were down to local systems,  
8 organisations, around where they needed to put some of  
9 the funding to support the elective recovery so I think  
10 it's probably at a number of different levels.

11 **Q.** Did you get any sense, in your role in the southeast  
12 region at the time, that children, the recovery of  
13 children's procedures was less of a priority?

14 **A.** It's certainly not something that I explicitly recall.  
15 In fact, I think we were very focused on making sure  
16 that the elective recovery was done for all ages, but  
17 clearly there was, if you look at the scale, and  
18 I accept that, you know, there's a difference in terms  
19 of the size of the elective waiting lists, you know,  
20 there was a significant focus also on some of the  
21 longest waits which tended to be in adult services, you  
22 know, we had potentially adults that were waiting for  
23 ophthalmology procedures that, you know, their sight  
24 would have suffered as well.

25 So I guess what I'm trying to say is there's  
29

1 data was suggesting the children's waiting list size was  
2 increasing at twice the rate of the adult list, and then  
3 you set out below one of the recovery toolkits that  
4 NHS England published, setting out what regions the  
5 system and providers or what actions they should take to  
6 accelerate the recovery of children's elective services.

7 But can I ask you in a general sense, do you know,  
8 Mr Burton, whether those toolkits and the steps that  
9 NHS England took actually did improve the waiting list  
10 size for children and young people in England?

11 **A.** Well, we still have a difference. I think it's fair to  
12 say we have seen some improvement, but there is still  
13 a difference that exists to this day. And I think what  
14 we've now got, you know, with the toolkits and the  
15 support that's gone in, we now have greater visibility  
16 of this, there's a requirement on systems, trusts to  
17 report on this by age and the recovery by age. So  
18 there's a greater visibility of this as well.

19 **Q.** Can we just have a brief look at just some of the data  
20 in relation to the backlogs and the waiting lists.

21 Could I have up on screen, please, page 135 of  
22 Mr Burton's statement.

23 And I just want to look at where the backlogs were  
24 being felt most keenly by children and young people, and  
25 indeed, look at the state of the waiting lists as we

31

1 a balance of prioritisation that was going on and also  
2 not every system was able to recover at the same pace as  
3 others. And you'll see kind of particularly as we went  
4 through wave 2, and the latter wave of Covid, it  
5 impacted regions in different ways, and the southeast,  
6 for example, we saw, particularly in wave 2, Kent very  
7 early on hit hard and then, you know, so I think --  
8 there wasn't one size that kind of fitted all.

9 **Q.** Can we be clear, you have said it wasn't something that  
10 you explicitly recall that children were less of  
11 a priority. Was there ever any diktat, document or  
12 advice or guidance sent out that explicitly said  
13 children were to be less of a priority when it came to  
14 recovering elective care services?

15 **A.** Absolutely not, and I think, to the contrary, you will  
16 see, and in my statement, you know, we've provided  
17 information about where there were, you know, toolkits,  
18 guidance, etc, around elective recovery, and certainly  
19 the children and young people's team, the transformation  
20 team, our National Clinical Director, Simon Kenny, for  
21 children and young people, were heavily thinking about  
22 this early on, particularly in kind of the summer of  
23 2020.

24 **Q.** Yes. All right. Well, we can see on the screen,  
25 though, at paragraph 303, that even by August 2022, the  
30

1 move through the pandemic and, indeed, up to 2024.

2 And we can see on screen, if it helps you, and it's  
3 your page 135 as well, Mr Burton, that there was  
4 a ranked list of services reporting existence of  
5 a backlog, by May, and 82% were reporting a backlog in  
6 children and young people's therapy interventions such  
7 as speech and language. And we can see as we go down  
8 that table, percentages decreasing through different  
9 services that children and young people needed, all the  
10 way down to no backlog in the rapid response services.

11 What are the rapid response services?

12 **A.** So that would be, you know, community children's nursing  
13 team that needed to provide, you know, rapid input into  
14 care of a child.

15 **Q.** So it's --

16 **A.** Which you would expect by -- rapid by nature would mean  
17 that you wouldn't be waiting because it's an immediate  
18 response.

19 **Q.** But significant backlogs as we go back up through that  
20 table, in relation to speech and language, community  
21 paediatric services, occupational therapy, audiology,  
22 and everything in between. So that was the kind of  
23 services that had the backlogs, and indeed, there are,  
24 there's data available on waiting lists that is kept by  
25 NHS England across all children's community health

32

1 services, and I'd just like to look, please, at page 139  
2 and your paragraph 433, Mr Burton.

3 We can see here that where data was available the  
4 total wait list across all community health services for  
5 children and young people was 215,000-odd at June 2022.  
6 It remained stable until winter 23' and '24, but if we  
7 look, it's actually rising by the time the table ends in  
8 April 2024. And so rather than getting better, it's got  
9 worse, if I may put it like that.

10 Can you help with why it is that as we came out of  
11 the pandemic, and are now no longer in the active stages  
12 of the pandemic, the waiting list has continued to  
13 increase?

14 **A.** So I think there's a number of different factors here,  
15 some of which are, you know, recovery from the pandemic,  
16 and, you know, the ongoing impact, but there are other  
17 things here as well. So there have been an increase in  
18 numbers of children coming into autism and ADHD  
19 services, there's a demand on SEND services as well, and  
20 there are continuing to be workforce constraints in some  
21 of these services as well, for example, you know, within  
22 speech and language therapy and places like that.

23 So demand has not gone down; demand has continued to  
24 go up after the pandemic and, you know, community  
25 services are continuing to face pressures from a number

33

1 of the reasons there why waiting list sizes could not be  
2 reduced. And if we go to -- that's it, thank you very  
3 much -- it's coming up on screen now:

4 "Providers consistently reported workforce  
5 availability, and an increase in demand and referrals,  
6 as the biggest obstacles to reducing waiting lists."

7 And we can see there the bottom category in dark  
8 blue, workforce availability was a key driver of this,  
9 increase in demand, workforce capability and skill mix.

10 Does that mean you didn't have the right staff  
11 available to deal with these challenges?

12 I see you nodding.

13 **A.** That's right, yeah.

14 **Q.** What's the "other" category?

15 **A.** I would have to -- I would have to look. There may be  
16 some very specific local circumstances, for example,  
17 within that, I would imagine, but I'm very happy to look  
18 into the "others".

19 **Q.** All right. And "Estates issues", is that because some  
20 of the children's wards were given over to adult  
21 services?

22 **A.** But, I mean, this period of time, October 2022, I would  
23 think that we would start to have been coming out of  
24 that. So there may well be other estates-related  
25 issues -- you know, availability of clinic space, it may

35

1 of different areas.

2 **Q.** Is there any sense that some of the rise might be  
3 attributable to people who delayed coming forward in the  
4 pandemic and seeking access to community health  
5 services, but of course then you get a rise when  
6 eventually they do come forward and they're potentially  
7 presenting with worse or certainly not better symptoms?

8 **A.** I don't think I'm able to answer that. I'm happy to  
9 look into it but I don't think I'd be able to give you  
10 an answer to that.

11 **Q.** If we keep up on screen, though, please, paragraph 434,  
12 below the graph, you say there that of the children  
13 currently on community health service waiting lists, the  
14 largest proportion have been waiting between 18 weeks  
15 and a year, and in April 2024, 88,000-odd children have  
16 been waiting between 18 weeks and a year. 32,000-odd  
17 have been waiting between a year and two years and over  
18 3,832 children have been waiting over two years.

19 So on any view, there's still a large number of  
20 children that are waiting from a year upwards for  
21 community health services.

22 Can you identify why waiting list sizes could not be  
23 reduced and indeed are continuing to rise, and I think  
24 if you look at your paragraph 431, Mr Burton, you might  
25 set out there -- sorry, paragraph 436, my fault -- some

34

1 be availability of -- or the type of estate, it may be  
2 temporary closures, those kind of things -- but, again,  
3 we can get more detail if you'd like it.

4 **Q.** Just whilst on this, again, "Reported factors preventing  
5 reductions in waiting lists", that top green bracket:  
6 "Not considered a priority."

7 And you'll recall me asking you questions a few  
8 moments ago about whether there was a lack of  
9 prioritisation. Do you know, does NHS England know why  
10 or who is considered not to be a priority?

11 **A.** Yeah, well, I think the -- I think what I would say is  
12 I don't -- I would be very surprised if anybody didn't  
13 think that any of our patients or our children and young  
14 people are a priority, but what we have to do is clearly  
15 weigh up priorities because there is also -- within  
16 this, there is community waits. Not only for children,  
17 there are communities waits for adults. And I think  
18 this is one of the challenges that we all have working  
19 in the health services, managing competing priorities  
20 and demand for services.

21 **Q.** I just want -- we looked at some generalities. I would  
22 like just to spend a few minutes with you looking at  
23 some of the other services that were affected by the  
24 decisions taken during the pandemic, and in particular  
25 can I ask you about NHS England's public health

36

1 functions.

2 We know, as you set out in your statement, it's at  
3 paragraph 439 onwards, Mr Burton, that NHS England has  
4 some specific public health functions delegated to it by  
5 the NHS Act of 2006. I'm not going to ask you about  
6 vaccination programmes for Covid, but can I just ask you  
7 briefly about vaccinations and immunisation programmes  
8 for non-Covid conditions. And I think you say at your  
9 paragraph 441 that:

10 "Vaccines are not mandated for [children and young  
11 people] in England ... a parent may refuse consent for  
12 any or all of the vaccines for [children]. [But]  
13 children under the age of 16 may be able to provide  
14 consent ..."

15 If they are assessed as being competent. So  
16 that's the, sort of, legal framework.

17 There are a number of different vaccinations, as you  
18 set out at your paragraph 443: for babies under 1,  
19 children aged 1, school-age children.

20 I'm not going to go through all of the vaccines but  
21 it includes things like MMR, meningococcal vaccines,  
22 diphtheria, polio, all the usual vaccines that we may  
23 have had as children.

24 Can I just ask you about the decision to close  
25 schools that was taken. It clearly impacted on the

37

1 **Q.** But was NHS England able to recover and ensure that the  
2 children that missed out immunisation programmes whilst  
3 schools were closed did in fact catch up?

4 **A.** Yes.

5 **Q.** Right. Although there are still, obviously, the --

6 **A.** But there is still --

7 **Q.** -- ongoing concerns by people who perhaps are now  
8 vaccine hesitant, not just for Covid-19 vaccines?

9 **A.** Yes, yes.

10 **Q.** All right. I won't ask you any more about that, please,  
11 but can I ask you about dental care.

12 And I think you say in your statement, at  
13 paragraph 164, that before the pandemic, rates of tooth  
14 decay amongst 5-year-olds had been falling, but by 2020,  
15 there was nearly 23.5% of children aged 5 experiencing  
16 obvious signs of tooth decay.

17 And can you help really summarise what the impact of  
18 the pandemic was on the rates of tooth decay on children  
19 and the impact that actually had on children needing  
20 surgery for tooth decay?

21 **A.** So I can't give you the -- what was the impact on tooth  
22 decay, but in terms of dental services we had to, during  
23 the pandemic, stop routine face-to-face dentistry.

24 Now, we did continue to provide remote advice,  
25 analgesia, antimicrobials, et cetera. There was

39

1 ability for those immunisations that were delivered in  
2 school. And do I take it that whilst the school was  
3 closed, those immunisation programmes were paused until  
4 the school reopened; is that correct?

5 **A.** That's correct, yes.

6 **Q.** And can you help now with how those immunisations were  
7 able to be picked up once schools opened, and have we  
8 recovered back to immunisation levels that we had  
9 pre-pandemic or is there a disparity still?

10 **A.** Yeah, so there was a catch-up campaign that was done for  
11 those children that had missed or had to have their  
12 vaccines paused as a result of that.

13 I think one of the things that I would say is I'm  
14 deeply concerned, and in some ways terrified, by the --  
15 some of the vaccine rates within children and young  
16 people. If you look at measles, for example, the cases  
17 of measles in this country, we have too many cases of  
18 measles. I'm deeply concerned that we are -- we have  
19 vaccine hesitancy going on now, so we have other things  
20 playing in here now.

21 **Q.** Let me pause you there, because her Ladyship will have  
22 heard a lot about that in the vaccines module, which was  
23 clearly focused on the Covid-19 vaccines, and clearly  
24 you're talking about a broader range of vaccines.

25 **A.** Mm.

38

1 a service set up to help support those in most need  
2 through 111, but clearly we had to reduce the services  
3 quite significantly. And that did impact children and  
4 young people, because actually children and young people  
5 are the -- you know, tend to be a heavy user of dental  
6 services, for the reasons you've explained, but also  
7 more routine care that is given. For example, some of  
8 the preventative aspects had to stop during the  
9 pandemic, temporarily, whilst -- you know, whilst we  
10 responded to the pandemic.

11 **Q.** Yes, in fact there's a graph that sets out, for example,  
12 the population -- sorry, proportion of the population  
13 that was seen by an NHS dentist during the pandemic.

14 Can I have up on screen, please, page 57 and that  
15 graph, thank you. And in fact this covers children and  
16 indeed all the way up to adults. But if we look at the  
17 green line, which is representing children aged between  
18 the ages of 10 to 14, in September 2018 nearly 70% of  
19 children in that age bracket were seeing an NHS dentist,  
20 and, look, it falls then, as we enter the pandemic, from  
21 nearly 70% down to just below 30%. And there are  
22 similar declines across the ages of children, and, for  
23 what it's worth, in adults seeing NHS dentists?

24 And I think you go on to say that tooth decay was  
25 the leading reason for hospital admissions in the 5-9

40

1 age groups.

2 So if we look at the red line on this graph, was it

3 about 67%-ish were seeing NHS dentists of that age group

4 pre-pandemic, and again, that drops to somewhere

5 around 27%, 28%, looking at the graph, during the

6 pandemic, and indeed, drops lowest in March 2021.

7 **A.** So, yeah, this is a 12-month roll-in, so you'll see it

8 impact there.

9 **Q.** Yes, steady decline. And then a rise?

10 **A.** Yeah.

11 **Q.** I think you say in your statement that, given that tooth

12 decay is the leading reason for hospital admissions in

13 the 5-9 age group, and indeed there is a link here with

14 children living in deprived circumstances in particular

15 who were affected, they -- children living in deprived

16 areas are up to three and half times -- have three and

17 a half times higher rates of decay than children living

18 in non-deprived areas.

19 And indeed, there were -- if we look at elective

20 admissions for dental care.

21 Could we have up on screen, please, page 61 and the

22 graph.

23 We have there:

24 "Elective admissions for tooth extractions with

25 a primary diagnosis of dental caries (tooth decay) [in

41

1 correct?

2 **A.** That is correct, yes.

3 **Q.** Right. Can you help us with what PIMS actually is.

4 **A.** Yeah, so PIMS-TS was -- it's an inflammatory response

5 that happened -- that was found to have happened as

6 a result of Covid for about four to six weeks after, and

7 can cause quite serious illness in children, impact on

8 organ failure, et cetera. So it's -- and resulted in

9 some children in -- needing intensive care treatment.

10 So this was one thing that was identified actually

11 quite rapidly, back in April 2020, early in the

12 pandemic, and actually that was identified very quickly,

13 because of the significant intelligence networks that we

14 have with frontline clinicians feeding in nationally

15 to -- to rapidly respond to that.

16 **Q.** Right. And I think you say PIMS is quite a rare

17 condition, it affects about one in every 3,000 children,

18 but where a child does develop PIMS, actually it often

19 requires hospital admission --

20 **A.** Yeah.

21 **Q.** -- if not to paediatric intensive care units?

22 **A.** That's correct.

23 **Q.** All right. The first case of PIMS was identified in

24 April 2020 and you say that there was a working group

25 set up in May 2020 to try and reach a consensus on the

43

1 layman's terms] ..."

2 We can see there, there was, what, just over

3 2,500 children pre-pandemic aged 10 to 17 being admitted

4 for planned tooth extractions.

5 And look, if we look at April 2020, it drops to,

6 what -- is that below 100 or there or thereabouts?

7 I think 103 children being admitted.

8 So high admissions pre-pandemic, significant drop

9 off during the pandemic, but clearly a significant

10 impact on children needing tooth extractions for

11 whatever reason.

12 And it's fair to say, I think, Mr Burton, it's not

13 necessarily that they couldn't see a dentist, there may

14 be other reasons for tooth decay. Does that include

15 children not brushing their teeth?

16 **A.** It absolutely does. And also, you know, sugar, sugary

17 foods, sugary drinks, all of those factors impact

18 a child's dental care.

19 **Q.** Right. We've looked at some specific impacts of the

20 pandemic, but can I ask you about two particular

21 conditions -- and a change of topic, please -- and ask

22 you about paediatric inflammatory multisystem system,

23 PIMS, to use the acronym.

24 And I'd like, then, to talk separately about

25 Long Covid because they are separate conditions; is that

42

1 most appropriate diagnosis and, indeed, treatment for

2 PIMS. And I think you say there's around 2,000 children

3 affected in England by PIMS.

4 **A.** Yeah.

5 **Q.** Is that correct?

6 **A.** That's correct.

7 **Q.** All right. And was the work done in relation to PIMS

8 separate to the work done in relation to Long Covid?

9 **A.** Yes.

10 **Q.** Right. Okay.

11 **A.** And, you know, reflective of the rapid need to respond

12 to this very early in the pandemic.

13 **Q.** So that whilst it is right, generally, that children

14 were less severely clinically affected by Covid, where

15 there was the contraction of either PIMS or indeed as

16 Long Covid, it could actually have very significant and

17 severe and debilitating effects on the children?

18 **A.** Absolutely, yes.

19 **Q.** All right. Let me ask you about Long Covid, then,

20 please, and your paragraph 698.

21 Her Ladyship will recall from Module 3 that in

22 October 2020 NHS England announced a Long Covid plan.

23 Now, your Ladyship may recall that, I think,

24 Professor Powis had a meeting with a number of the

25 groups that were trying to promote the Long Covid

44

1 effects on children, and it was in October 2020 that the  
 2 plan was announced by NHS England.  
 3 Can you help me with this: the Long Covid plan did  
 4 not explicitly include provision for children or  
 5 expressly refer to children and young people in the  
 6 plan. Do you know why there wasn't express reference to  
 7 Long Covid in children in the October 2020 plan?  
 8 **A.** As far as I'm aware, this was -- it was an all-age plan  
 9 so it wasn't specifically called out. And again,  
 10 I guess just to say, you know, October 2020, this was  
 11 also new and emerging, in terms of a condition, and  
 12 therefore, you know, understanding what needed to  
 13 happen.  
 14 **Q.** By June 2021, though, NHS England had committed to  
 15 establishing 15 hubs for children and young people with  
 16 Long Covid, and those hubs included paediatric services  
 17 and extending access to clinical expertise in that  
 18 field.  
 19 You have seen, though, I think, Mr Burton, concern  
 20 that notwithstanding the work done by NHS England with  
 21 both the plan and, indeed, the hubs, there was real  
 22 concern that there was delay in the recognition of  
 23 Long Covid amongst paediatricians, and can I just ask,  
 24 through you, to have a look, please, at  
 25 INQ000587960\_2022.

45

1 and Young People was concerned about this, you know,  
 2 fairly early on, you know, and recognising that this was  
 3 a new disease process. You know, back in kind of June,  
 4 July time where, you know, and would say to me -- if he  
 5 was here now -- that actually clinicians will recognise  
 6 that whenever a virus impacts somebody, there might well  
 7 be some post-viral process that occurs.  
 8 And I think, therefore, what you see in the response  
 9 from NHS England is very much, as we got more  
 10 understanding of this, services being set up and also,  
 11 you know, services being deliberately set up for  
 12 children and young people, but I can also understand  
 13 from reading, you know, the statement that is online  
 14 here, this was also a time when there was a very kind of  
 15 confused picture going on, so I can understand the fact  
 16 that, you know, we had children impacted by disruption  
 17 in education and the impacts of the pandemic that would  
 18 have also, you know, caused other concerns at the time.  
 19 **Q.** Right. I think you've also seen that there were,  
 20 indeed, children and young people that contributed to  
 21 the Children and Young People's Voices report who made  
 22 similar comments to those by the experts, where they  
 23 felt they were being dismissed, or they weren't being  
 24 taken seriously, and the like. Can you help with, from  
 25 NHS England's perspective, did -- what did NHS England

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1 This is an extract from an expert report by Dr Segal  
 2 and Professor Whittaker that was commissioned by the  
 3 Inquiry, and at their paragraph 49, they had made  
 4 reference above to a delay in the collective  
 5 realisation, as they call it, that Long Covid affected  
 6 children. There was likely also a minimisation and  
 7 disbelief by some healthcare professionals, saying  
 8 invisible disabilities are recognised as challenging for  
 9 people to understand, hence disabled children and young  
 10 people may not be believed. Some children's symptoms  
 11 were thought to be due to reasons other than Long Covid,  
 12 such as mental health presentations, symptom  
 13 exaggeration, school refusal, and some Long Covid  
 14 diagnoses were dismissed. And indeed some clinicians  
 15 labelled parents as anxious, hypervigilant and assumed  
 16 exaggeration of their children's symptoms, again  
 17 refuting Long Covid diagnosis and support.

18 Did you get any sense in your role at the time that  
 19 there was some paediatricians and clinicians minimising  
 20 and disbelieving children presenting with Long Covid  
 21 symptoms?

22 **A.** So it's not something personally I came across in my  
 23 interactions with clinicians. In fact, from an  
 24 NHS England perspective, I think our clinicians,  
 25 certainly our National Clinical Director for Children

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1 do to try and either improve the understanding of  
 2 paediatric Long Covid or to remedy the minimisation of  
 3 Long Covid symptoms? What steps did NHSE take?  
 4 **A.** Absolutely. So I think, look, we took a number of  
 5 different steps to support this, so certainly our  
 6 clinicians worked with organisations or family  
 7 representatives that were focused on Long Covid,  
 8 certainly held a number of webinars to provide  
 9 information, advice, guidance. You've got the NICE  
 10 guidance that was put out in September 2020. You know,  
 11 there was funding that was put in for, you know, I think  
 12 £10 million worth of funding that was put in October to  
 13 set up Covid clinics. There was additional funding then  
 14 in 2021, I think £2.5 million which was dedicated for  
 15 children and young people's Long Covid services.  
 16 So I think, you know, this was clearly new and  
 17 emerging, and as that more information and, you know,  
 18 evidence base came online, that was being used to  
 19 communicate.

20 **Q.** Just finally on Long Covid, I think you say in your  
 21 paragraph 707 onwards in relation to data on children  
 22 and young people with Long Covid, clearly data was  
 23 eventually obtained. One understands why it couldn't be  
 24 until, indeed, Long Covid was formally recognised as  
 25 a condition, but in terms of monitoring and reporting

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1 data by the children and young people's Long Covid hubs,  
2 you say there was data on the number of referrals  
3 collected from March 2021 to June 2022.

4 **A.** Mm-hm.

5 **Q.** The results weren't published, though, because the small  
6 numbers could lead to identification and only eight out  
7 of 14 of the hubs regularly submitted data, and in fact,  
8 there was poor data completion and poor data quality,  
9 hence why data wasn't in fact published.

10 Can you help with what efforts, if any, have been  
11 made to improve data collection from -- in relation to  
12 children and young people with Long Covid.

13 **A.** That is something I'm not able to answer. I'm happy to  
14 come back with a response on that.

15 **Q.** All right. Can I turn to some overarching observations,  
16 please, with you, Mr Burton. And you say in your  
17 lessons learned and recommendations section of your  
18 statement that the needs of children and young people  
19 can easily be overlooked, and pandemic preparedness  
20 needs to account for the physiological differences, but  
21 the emotional, developmental, educational differences  
22 and the like. What is NHS England doing to prepare now  
23 for those, and take account of the different needs and  
24 demands that a pandemic may have on a children and young  
25 person (sic).

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1 doing, I would like just to draw your attention into the  
2 pack around the kind of direct impact. We did almost  
3 have an incident within an incident around RSV and the  
4 impact on children and young people and I think it's  
5 important to just refer to that, because that gave us  
6 the opportunity to think about how do we scale up and  
7 respond to an increase in, a significant increase in RSV  
8 at the time for children and young people. So surge  
9 plans and develop those.

10 **Q.** Pause there, Mr Burton, because not everyone will know  
11 what RSV is. I know it's a respiratory virus and I can  
12 never pronounce the second --

13 **A.** Syncytial.

14 **Q.** Just help us. What is it and why is it such a concern  
15 for children and young people?

16 **A.** Yes. So it's a respiratory virus that we've tended to  
17 get an annual increase in every single year which puts  
18 extreme pressure across the health service, including  
19 into in paediatric intensive care units, primary care,  
20 et cetera. And what we saw happen during the pandemic  
21 was because children weren't mixing in 2020, we were  
22 concerned, going into 2021, that we would see  
23 a resurgence of that, and we did. We saw it earlier,  
24 and we saw, I think it was seven times the normal kind  
25 of levels of RSV than previous years.

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1 **A.** If I can just draw this into two spaces.

2 **Q.** Certainly.

3 **A.** So I think there is -- we have to be prepared for  
4 a pandemic that impacts children and young people in  
5 a way that perhaps Covid didn't directly impact. So if  
6 a virus happened tomorrow and a pandemic occurred that  
7 impacted children and young people, if you think, if  
8 I just simply put the kind of -- we've got, you know,  
9 just over 3,000 level 3 critical care beds for adults,  
10 we've got 312 that are commissioned for children. So  
11 the scale of stepping up a response for children is  
12 different. The children's workforce is smaller. You  
13 know, even kind of, you know, I'm an adult trained  
14 nurse, but drug calculations for children are that much  
15 more complex. There's a whole complexity around the  
16 workforce that we would need to consider.

17 That's not to say that you couldn't change some of  
18 the adult critical care capacity for children, those  
19 older children. But clearly, we need to be prepared for  
20 a pandemic that directly impacts.

21 There are then also, and I think particularly the  
22 learning from this pandemic, is the indirect impacts of  
23 children and young people. So clearly the kind of, as  
24 you've said, the education impacts on health and  
25 wellbeing and mental health. So in terms of what we are

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1 And I think that's important because one of the  
2 things that has come out of the pandemic is that we will  
3 see resurgences of other viruses and conditions that  
4 will happen, and so, you know, being prepared for that  
5 is really important.

6 And just to go back to my point earlier about the  
7 importance of vaccines, we now have a vaccine for RSV  
8 since last year, available for pregnant women, to  
9 protect them, to protect babies and young people and  
10 this is why actually keeping vaccination rates high is  
11 something that's really important across the board for  
12 all conditions going into a pandemic.

13 **Q.** Can I come back to the preparedness point, though,  
14 because I think you say in your statement that there was  
15 no national pandemic preparedness exercises that  
16 NHS England was either involved in or aware of that  
17 focused on the specific needs of children and young  
18 people.

19 **A.** Yes.

20 **Q.** And can I ask you, it may be difficult to answer, but,  
21 had there been, what difference do you think it would  
22 have made during the pandemic?

23 **A.** I think that's a very difficult question to answer.

24 **Q.** Because wouldn't we still have had to suspend --

25 **A.** Yes.

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1 Q. -- or pause elective care --  
 2 A. Yes.  
 3 Q. -- given the influx of numbers?  
 4 Let me ask you a different way, then. What do you  
 5 perceive the benefits being of a specific children and  
 6 young people focused pandemic preparedness exercise?  
 7 A. I think the benefits of that are a greater preparedness  
 8 for areas such as, you know, how do you scale up  
 9 critical care services for children and young people.  
 10 What do we need to do around the equipment that's  
 11 available? The workforce, the training. All those  
 12 considerations. And I think also it's to test out what  
 13 some of the unintended consequences might be of making  
 14 those decisions.  
 15 So particularly with the smaller children and young  
 16 people's workforce, if you have to scale up into more  
 17 critical care services, with children's experienced  
 18 nurses, doctors, et cetera, what does that do to other  
 19 parts that we might need to continue to make sure  
 20 happen?  
 21 Q. Do you think that would also include potentially looking  
 22 at the consequences of redeployment?  
 23 A. Yes.  
 24 Q. We have later this afternoon a witness coming from the  
 25 Institute of Health Visiting, who is concerned about the

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1 A. Well, I think just to say I think we really did try to  
 2 keep the voices of children and young people at the core  
 3 of everything we did, so I think any response or any  
 4 future response needs to continue to make sure that we  
 5 have not only a focus on children through all of the --  
 6 kind of, all-age services that we provide, but also  
 7 a kind of coordinating point, which the Children and  
 8 Young People's Transformation Board in many ways did  
 9 during this pandemic, to bring together those different  
 10 components across NHS England, Department for Education  
 11 and others.  
 12 The other thing -- the other one thing I would say  
 13 which I think is an important recommendation is around  
 14 data, because I think what we've seen -- and, you know,  
 15 you've taken me through lots of data this morning -- is  
 16 that the importance of being able to disaggregate data  
 17 by age is important, and also the work that needs to be  
 18 done, and there's a commitment in the 10 Year Health  
 19 Plan, around a unique identifier for children and young  
 20 people, which crosses beyond just health into other  
 21 areas, like education and social care. So I think  
 22 having these additional things will enhance any  
 23 response.  
 24 Q. Can I ask you about that, because you've set it out at  
 25 your paragraphs 811 and 812. And I smile because you're

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1 number of health visitors that were redeployed during  
 2 the pandemic.  
 3 A. Yes.  
 4 Q. And clearly, an impact of redeployment has been that the  
 5 healthcare system was unable to recover as quickly, as  
 6 we looked at. So, clearly -- do you know if Operation  
 7 Pegasus has included a focus on the specific needs of  
 8 children and young people?  
 9 A. I think it would be wrong for me to be able to say that  
 10 at the moment.  
 11 Q. All right.  
 12 A. We've been -- I've taken part in the first -- the early  
 13 days of the simulation, and I think we will need to see  
 14 what the next phase is for me to be able to confirm that  
 15 either way.  
 16 Q. All right.  
 17 Just finally from me, please, one of the other final  
 18 reflections you have is ensuring that children and young  
 19 people's interests are represented in formal response  
 20 structures.  
 21 Clearly, NHS England has the transformation  
 22 programme and the board that you told us about right at  
 23 the beginning of your evidence, but can you give us any  
 24 concrete recommendations or ideas for how there could be  
 25 better engagement for children and young people?

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1 not the last witness, and certainly not the first  
 2 witness, either, to have mentioned data to her Ladyship.  
 3 But can we be realistic, Mr Burton: how realistic do  
 4 you think it would be to have a single, unique  
 5 identifier for each child across not just health systems  
 6 but social care systems as well, and educational  
 7 services, which would effectively link up health, social  
 8 care and education? It sounds wonderful in theory, but  
 9 how realistic is it in practice?  
 10 A. Well, look, there's clearly work to be done to get to  
 11 that point and in many ways I think, you know, we are  
 12 certainly looking at whether the NHS number is the  
 13 unique identifier because everybody has an NHS number.  
 14 I don't think it's a question of realism, I think it's a  
 15 question of we need to do this because it's really  
 16 important. You know, children, and as you've seen kind  
 17 of from the unintended consequences, children are not an  
 18 island. This isn't -- you can't put a child in a health  
 19 box, in an education box, in a social care -- it crosses  
 20 over, safeguarding crosses over all of those. So  
 21 I think this is not a question of whether we should do  
 22 it; we have to do this and find a way to do it.  
 23 MS CAREY: Right.  
 24 Mr Burton, they are all the questions that I have  
 25 for you. I know there are some Core Participant

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1 questions but I wonder, my Lady, if it might be sensible  
 2 to take our midmorning break and return to the Core  
 3 Participants after that?  
 4 **LADY HALLETT:** Certainly. I understand you're content to  
 5 come back after the break, Mr Burton.  
 6 **THE WITNESS:** Yes, that's fine.  
 7 **LADY HALLETT:** Okay, well, thank you very much indeed, and,  
 8 as we've got through quickly you can have until 11.35  
 9 for a break.  
 10 **MS CAREY:** Thank you, my Lady.  
 11 **(11.16 am)**  
 12 **(A short break)**  
 13 **(11.35 am)**  
 14 **MS CAREY:** My Lady, thank you. I hope you can see and hear  
 15 me okay.  
 16 **LADY HALLETT:** I can, thank you.  
 17 **MS CAREY:** And it's Ms Beattie on behalf of the Disabled  
 18 People's Organisations to ask questions next.  
 19 **LADY HALLETT:** Thank you.  
 20 Ms Beattie.  
 21 **Questions from MS BEATTIE**  
 22 **MS BEATTIE:** Thank you, my Lady.  
 23 Mr Burton, I ask questions on behalf of national  
 24 Disabled People's Organisations.  
 25 On 3 June 2020 a letter was sent by NHS England and  
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1 meant that we had to continue to support the efforts  
 2 around critical care, elective recovery.  
 3 There were steps that were taken, and I think within  
 4 my evidence pack there is a letter that was sent,  
 5 I think in December 2020, by the Chief Allied Health  
 6 Professional around about the restoration of allied  
 7 health professionals back into community services and  
 8 the importance of that.  
 9 But I think it's also important to remember it's  
 10 very easy to stop things, but actually to scale them  
 11 back up and restart them is sometimes more difficult,  
 12 given the scale of the challenges that were happening at  
 13 the time.  
 14 **Q.** I mean, were you aware that some of those concerns  
 15 involved things like inappropriate redeployment of  
 16 therapists to cleaning roles?  
 17 **A.** I'm not aware that therapists were redeployed to  
 18 cleaning roles. It's certainly never -- something that  
 19 hasn't come up to me in my time in my role.  
 20 **Q.** And that those concerns, particularly from the Royal  
 21 College of Speech and Language Therapists, persisted  
 22 throughout 2021, such that they were issuing open  
 23 letters as late as November 2021 concerned about that  
 24 redeployment?  
 25 **A.** I haven't seen those specific letters from the speech  
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1 NHS Improvement providing guidance on the restoration of  
 2 community health services for children and young people.  
 3 And that letter said, at page 5, that children's allied  
 4 health professional services, for example, speech and  
 5 language therapy or wheelchair services, should be  
 6 partially restored subject to prioritisation.  
 7 And at page 11, it said that, under the Coronavirus  
 8 Act, reasonable endeavours had to be made to ensure that  
 9 the provision in a child's education, health and care  
 10 plan was delivered.  
 11 But despite this, concerns were repeatedly raised  
 12 well into the pandemic, throughout 2021, that allied  
 13 health professionals working with children were being  
 14 inappropriately redeployed.  
 15 Do you accept that redeployment of allied health  
 16 professionals continued for far too long, and that the  
 17 steps taken to ensure that they were returned to  
 18 critical work with disabled children were insufficient?  
 19 **A.** So, thank you. I think I would just go back to the  
 20 scale of the challenge in 2020, and the scale of the  
 21 challenge that all services were having to respond to in  
 22 terms of redeploying staff, be that allied health  
 23 professionals, nurses, medical. We had to respond  
 24 throughout the period of the pandemic to different waves  
 25 of Covid, which meant that we had staff sickness, which  
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1 and language therapy organisation.  
 2 **Q.** The language in the June 2020 guidance letter, that  
 3 reasonable endeavours were required to secure provision  
 4 for children with education, health and care plans, was  
 5 used, and it did not say, for example, that all  
 6 practical steps should be taken to deliver that  
 7 provision to children with education, health and care  
 8 plans. Do you agree that that language did not  
 9 adequately convey the urgency of what are critical  
 10 services for disabled children and young people  
 11 delivered through education, health and care plans?  
 12 **A.** I guess, again, what I would come back to is the scale  
 13 of the challenge at the time. I think regardless of the  
 14 framing of the language, and I absolutely appreciate,  
 15 for disabled children and young people, the pressures  
 16 that were on them and their needs as well, but in the  
 17 context of June 2020, where we had still Covid cases, we  
 18 still had high numbers of staff off sick, we still had  
 19 to be continuing to respond to the needs of the pandemic  
 20 and restore services, I think it's not unreasonable to  
 21 have expected people to make their best endeavours to  
 22 restore services.  
 23 And also I think that I am mindful about the fact  
 24 that, and certainly within my roles in the region and my  
 25 experience of being a trust chief nurse, we would have  
 60

1 expected locally for that guidance, that letter, to be  
2 interpreted and to tailor the needs for the local  
3 community.

4 **MS BEATTIE:** Thank you, my Lady.

5 **LADY HALLETT:** You're up next.

6 **Questions from MS DOUGLAS**

7 **MS DOUGLAS:** Thank you, my Lady.

8 Mr Burton, I ask questions on behalf of Clinically  
9 Vulnerable Families and I have two questions about  
10 paragraph 84 of your witness statement on page 31, and  
11 that's where you've outlined analysis of the number of  
12 deaths in children in England from Covid-19.

13 This analysis estimated that 88 children and young  
14 people died of Covid-19 in England during the first 26  
15 months of the pandemic. You went on to explain that 90%  
16 of those children had an underlying chronic condition.

17 Mr Burton, if they had an underlying chronic  
18 condition, can you confirm that those 90% of children  
19 who died from Covid-19 would have been classed as  
20 clinically vulnerable?

21 **A.** I wouldn't be able to specifically confirm for every  
22 single one of those cases. I mean, it's something we  
23 can look at, but I wouldn't want to give you  
24 a definitive answer on that. I would imagine that some  
25 of them would be but I wouldn't want to --

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1 expected regardless of the management of that condition?

2 **A.** Again, I can look into the definitions of this, but  
3 I mean, you use diabetes as an example there, that I  
4 wouldn't consider as a life-limiting condition, that  
5 it's a manageable condition.

6 **MS DOUGLAS:** Thank you, Mr Burton.

7 **LADY HALLETT:** Thank you, Ms Douglas.

8 Mr Broach should be across the hearing room.

9 **Questions from MR BROACH KC**

10 **MR BROACH:** Thank you, my Lady.

11 Mr Burton, I appear for the Children's Rights  
12 Organisations. Can I ask, please, what assessment, if  
13 any, did NHS England make of whether both service  
14 suspensions during the pandemic and the shift to  
15 digital-first models disproportionately impacted  
16 children from low income or otherwise disadvantaged  
17 families?

18 **A.** Thank you. So again, I don't think I'm able to answer  
19 what specific assessment happened in relation to that  
20 but certainly there was due consideration given to the  
21 change of services to digital online, be that for adults  
22 or for children. And that's why there was never  
23 a blanket "everything has to move online". So if there  
24 were families or children and young people that couldn't  
25 access care via digital means, you know, there was an

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1 **Q.** Would it be fair to infer that most, if not all, of  
2 those children with underlying chronic conditions would  
3 tend to be clinically vulnerable?

4 **A.** Sorry, could you repeat the question?

5 **Q.** Would it be fair to infer that those children with  
6 underlying chronic conditions are clinically vulnerable?

7 **A.** I think you could make that inference but again, you  
8 know, in terms of were they on a shielding list or  
9 something, I couldn't confirm that.

10 **Q.** Thank you.

11 And the second question, you go on to say that 80%  
12 of the children who died had a life-limiting condition,  
13 and can I ask, does the category "life-limiting  
14 condition" include children with serious but manageable  
15 conditions which may affect their life expectancy, for  
16 example type 1 diabetes, or is it limited only to  
17 conditions where a death is expected regardless of  
18 management?

19 **A.** Again, sorry, could you repeat the question.

20 **Q.** That paragraph refers to 80% of the children who died  
21 having a life-limiting condition. I'm just trying to  
22 explore there whether, when you say life-limiting  
23 condition, do you mean children with a serious but  
24 manageable condition which may affect their life  
25 expectancy or do you mean conditions where death is

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1 expectation, you know, those needing emergency care, for  
2 example, continued to receive that face to face.

3 **Q.** Do you accept that there should be formal assessment of  
4 whether those kinds of changes are going to have  
5 a disproportionate impact on particularly vulnerable  
6 groups?

7 **A.** I think with anything that we do at NHS England or  
8 within the NHS we should consider all types of  
9 inequalities, and the impact of inequalities in  
10 everything that we should do.

11 **Q.** Thank you. And were children and/or families consulted  
12 as part of any consideration of the consequences and the  
13 proportionality of the impact of these measures?

14 **A.** Again, sorry, can you just be -- in relation to the  
15 change to online --

16 **Q.** The suspension of various services and the change to  
17 digital first working.

18 **A.** So I think, given where we were at the pandemic and the  
19 initial response, had to be very much around -- there  
20 wasn't wide consultation that was done on some of these  
21 changes, because of the nature of the emergency that we  
22 were in, and we were having to do guidance in, you know,  
23 a matter of hours and days to be able to do this. So  
24 a normal type of consultation that we would normally do  
25 on significant changes didn't happen in that respect,

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1 but we did try to make sure, where guidance had been  
2 issued, as we went through the pandemic, you can see  
3 that changes were made to guidance as we got more input  
4 from different organisations and people.

5 **MR BROACH:** Thank you, Mr Burton.

6 Thank you, my Lady.

7 **LADY HALLETT:** Thank you, Mr Broach.

8 That completes the questions we have for you,  
9 Mr Burton. You've mentioned a number of times the need  
10 for planning and the need for better data. You don't  
11 have to persuade me of that after all the evidence I've  
12 heard during the course of the Inquiry so far, and I'm  
13 sure I'm going to hear more.

14 So thank you very much indeed for the help you've  
15 given to the Inquiry and in preparing the witness  
16 statement you have. And I don't know if you have had  
17 colleagues help you with preparing the witness statement  
18 and with preparing for today, but can you please pass on  
19 my thanks to them for their help to the Inquiry.

20 **THE WITNESS:** Thank you.

21 **LADY HALLETT:** Thank you.

22 **MS CAREY:** My Lady, there will just be a brief pause before  
23 we bring in the next witness, who is  
24 Professor Steve Turner.

25 Yes, I think the witness can be sworn, please.

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1 24,000 members across the UK?

2 **A.** That's right.

3 **Q.** And I think you may have been present when the Chief  
4 Nursing Officer just gave evidence this morning.

5 **A.** I was.

6 **Q.** Clearly we had an England-focus with that witness, but  
7 if at any time you're able to help us with the position  
8 in the devolved nations, please feel free to do so, not  
9 least because RCPCH is a UK-wide body.

10 **A.** With pleasure.

11 **Q.** All right. The Royal College is responsible for  
12 education, training, setting professional standards, and  
13 informing research and policy, as you set out. And  
14 I think during the pandemic you explain that the college  
15 engaged with a number of NHS organisations, NHS England,  
16 Public Health England as was, now UKHSA, Department of  
17 Health and Social Care, Department for Education, and  
18 indeed your college offices in the devolved nations  
19 having similar engagement with governments and  
20 organisations, perhaps less so in Northern Ireland  
21 though, in the run-up to the pandemic, given the state  
22 of the government as it was in the few years preceding  
23 2020?

24 **A.** Yes.

25 **Q.** All right. Can I ask you at the outset, you say at your

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1 **PROFESSOR STEVE TURNER (sworn)**

2 **Questions from COUNSEL TO THE INQUIRY**

3 **LADY HALLETT:** Thank you for coming to help us,  
4 Professor Turner.

5 **THE WITNESS:** You're very welcome.

6 **MS CAREY:** Professor, your full name, please.

7 **A.** Yes, good morning. I am Stephen William Turner.

8 **Q.** Thank you. You are, I believe, President of the Royal  
9 College of Paediatrics and Child Health.

10 **A.** I am.

11 **Q.** And have been in that position since March 2024.

12 **A.** Yes.

13 **Q.** I think prior to that, as you set out in your statement,  
14 which is INQ000651508, you were the RCPCH -- for  
15 short -- Registrar from spring 2021 to spring 2024, and  
16 the Officer for Scotland in the five years preceding  
17 that?

18 **A.** Correct.

19 **Q.** All right, I think you are a consultant paediatrician in  
20 general and respiratory paediatrics, currently  
21 practising in the Royal Aberdeen Children's Hospital?

22 **A.** That is correct.

23 **Q.** All right. Now I think, Professor, you set out in your  
24 statement a little bit about RCPCH. You are the  
25 membership body for paediatricians and have over

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1 paragraph 7:

2 "The extent to which these public bodies ensured  
3 children and young people were central to  
4 decision-making varied throughout the pandemic."

5 Can I ask you, please, are you able to give us an  
6 example of some good government decision making which  
7 focused on children and young people? And then I'm  
8 going to ask you perhaps for an example where there  
9 wasn't that focus.

10 **A.** You start with the harder question. I think that --  
11 just to start -- going back to March 2020, they were  
12 unspeakably difficult times with a lot of uncertainty,  
13 and I think that collectively across the UK, the  
14 governments made the most sensible decision in doing  
15 what they did, and this is a theme that I might come  
16 back to a few times in the time that we've got together.

17 The revision, the reassessment of that with the  
18 focus on children, would -- and I argue should -- have  
19 been made and changes should have been made.

20 So, in answer to your question what did government  
21 do well, I think governments recognised that what they  
22 were doing to children was causing them huge indirect  
23 harm. I think there was awareness of that, but the  
24 focus of government, which was understandable at the  
25 time, was to look after the other end of the age range.

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1 So I think, to be -- and I have great sympathy and  
2 I spoke to lots of people who were in the thick of  
3 things in those days, in the absence of any experience,  
4 and in the absence of data, initially those decisions  
5 were understandable. So fair enough.

6 In answer to your question what did they not do so  
7 well, and I think this is across all four nations, there  
8 was not enough respect given to children. There was not  
9 enough consideration given to the innumerable harmful  
10 indirect harm that was done to them as a consequence of  
11 the provisions made around Covid. And those decisions  
12 and the low priority of children in our society, which  
13 actually is everybody's responsibility in this room,  
14 continues to frustrate me, annoy me, but enthuse me to  
15 carry on championing for children and young people.

16 **Q.** Right. Did you or the Royal College get any sense of  
17 why there wasn't enough consideration given to, in  
18 particular, the indirect harms? Is it the fault of one  
19 department? One person? Systemic? Can you help?

20 **A.** Yeah -- no -- well, I can contribute. I think that when  
21 we started, children were on the second tier of  
22 priorities for us as a nation. I think if you look at  
23 investment, child outcomes, so for example, mortality  
24 rates, obesity rates, mental health rates, asthma  
25 deaths, these were all going in the wrong direction

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1 **A.** Mm-hm.

2 **Q.** Can you help, from your perspective and the college's  
3 perspective, was there sufficient engagement with  
4 children and young people? We've heard about from the  
5 previous witness a transformation board that was in  
6 place by NHS England, but perhaps UK-wide, was there  
7 sufficient engagement?

8 **A.** There's always room for more engagement.

9 **Q.** Of course.

10 **A.** You'll not be surprised to hear me say that. So as  
11 a college, we have children in our name, so we -- one of  
12 our roles is to advocate for children because on  
13 a national level there are very few advocates for  
14 children. We believe we're one of them. We have  
15 a group called &Us, and we sought the experiences of  
16 young people, and we expressed and reflected these views  
17 of their experiences across the four nations to  
18 governments and to other stakeholders, and I think that,  
19 if you cast your mind back, those people who had  
20 schoolchildren at that time, there were children  
21 everywhere. You could not avoid the fact that there  
22 were children sitting at home on tech not doing  
23 anything, and so I think the plight of children was --  
24 people were aware of it. But what I did not see was  
25 a translation of that awareness into something being

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1 before the pandemic started. So it's not a surprise to  
2 me that when the pandemic then hit us, that the  
3 wellbeing of children was always going to be on a lower  
4 trajectory, a poorer trajectory, than that for adults.

5 So I think if you break down the time course into  
6 what happened before the pandemic and then what happened  
7 during the pandemic, it's not a surprise that children  
8 were -- there was an awareness of children, I'm sure  
9 there was, because politicians will have had children  
10 and grandchildren, there will have been that awareness  
11 but that awareness did not translate to a consideration  
12 of: what harm are we doing to our children? There was  
13 no reflection on that. And if there was reflection,  
14 I didn't see any evidence of it. And five years down  
15 the line, you know, I was in clinic on Monday seeing 5-,  
16 6-year-olds who were still not toilet trained. And they  
17 missed out on that opportunity.

18 So children continue today to suffer for what we did  
19 during the pandemic, which is a partial reflection of  
20 what was already happening beforehand.

21 **Q.** Understood. We might look at some of the indirect  
22 impacts during the course of your evidence, but I think  
23 one of the things that perhaps might be emerging is the  
24 extent to which there was engagement with children and  
25 young people and therefore a focus on them.

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1 done about it.

2 And I'll just briefly talk about schools., you know,  
3 we put out a statement in May 2020 recognising the  
4 difficult decision that, you know, it is a risk to  
5 reopen schools, but it took an awful long time before  
6 that happened, and then it was done with social  
7 distancing and masks, and it was just not considering  
8 the wellbeing of children.

9 **Q.** Before I look at some of those impacts, I think one of  
10 the things you do say in your statement is that the  
11 college sought for children and young people to be more  
12 central to public communications in the pandemic --

13 **A.** Mm-hm.

14 **Q.** -- which I suspect, ergo, would help them engage with  
15 the issues.

16 **A.** Yeah.

17 **Q.** And I think you say the Royal College wrote to the  
18 Prime Minister, amongst others, asking him to host  
19 a briefing on children and young people but that  
20 suggestion was not taken up.

21 **A.** Yes.

22 **Q.** And you also wrote to the Secretary of State,  
23 Matt Hancock, to meet with children and young people.  
24 And I'd just like to look at the letter that was  
25 written.

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1 Can we have up on screen, please, INQ000620590.

2 We are in October 2020, so this is really now with  
3 a view to planning for the winter pressures and  
4 potentially a wave 2.

5 **A.** Yes.

6 **Q.** And we can see, as we scroll down, that the college  
7 wanted to have the opportunity to work with the  
8 Secretary of State to empower more young people and  
9 young adults UK wide to understand their role in the  
10 next phase of the pandemic, to follow and support  
11 others. And you set out how to try to mobilise what is  
12 up to 25% of the UK population and a threefold plan.

13 "Continue to support and promote young people as  
14 advocates ...

15 "Develop young people-focused Covid-19  
16 messaging ..."

17 And thirdly:

18 "Create with you [Secretary] an opportunity for a  
19 conversation with us as health youth ambassadors ..."

20 And it was, you said:

21 "Young people are already working with other  
22 UK Government teams and departments and ... charities to  
23 support [parts] 1 & 2, but we would like to start  
24 working with you and your team on scoping ... 3, an end  
25 of year youth/Secretary of State conversation."

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1 College satisfied with the response that it got from --  
2 in response to its letter?

3 **A.** We accepted that it was a busy time. I'm sure  
4 Mr Hancock was busy, but obviously we were disappointed  
5 that we were given soothing words which we could  
6 challenge but we weren't given an opportunity to do  
7 that. Yes.

8 **Q.** One part of the plan was to develop young people-focused  
9 Covid-19 messaging.

10 **A.** Mm-hm, yeah.

11 **Q.** Why was it considered by the college important that  
12 messaging should be particularly tailored to children  
13 and young people?

14 **A.** Well, it's always better to do things with people than  
15 to them, and I get less young all of the time and  
16 I don't speak -- the way I put a message across might  
17 not be the same way that a young person would either  
18 want to put it across or want to receive it, so we're  
19 very keen to co-produce things with young people.

20 **Q.** We've heard and indeed there is evidence from  
21 NHS England in particular about decline in attendance at  
22 A&E, decline in attendance at GP appointments, late  
23 presentation of children with various health  
24 difficulties. Do you think that tailored communication  
25 to children would have perhaps ameliorated some of that

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1 **A.** Mm-hm.

2 **Q.** And I think you have seen, Professor, a response from  
3 not Mr Hancock himself but someone in their  
4 correspondence team and if we go to page 3, the DHSC  
5 team responded in November, on the 30th, apologising for  
6 the delay, making the point that it was a busy time for  
7 Mr Hancock who was unable to commit to a meeting at that  
8 stage. And then setting out a number of things that the  
9 government says it was doing in relation to promoting  
10 the needs and welfare of children. It says:

11 "The Government takes child health very seriously.  
12 It knows that getting more children back into school is  
13 vital for their education and their wellbeing --  
14 particularly for the most vulnerable and  
15 disadvantaged ..."

16 I won't read out the whole letter, but if we go to  
17 this next page, please, an acknowledgement that the  
18 pandemic has left young people feeling anxious. There's  
19 been advice given.

20 "NHS services remain open and the government is  
21 providing £9.2 million of funding to national and local  
22 mental health charities to support adults and children  
23 affected by the pandemic."

24 A number of issues to pick up there with you,  
25 please. Firstly this: generally speaking, was the Royal

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1 decline?

2 **A.** Yeah, I -- yeah, I think young people would have liked  
3 a message to say, "We know it is rubbish out there, we  
4 know that when your parents are fed up with you, you're  
5 grounded, and I know the country has grounded you for  
6 months. We know. We realise it. And we're really  
7 sorry about it."

8 That was just never said.

9 **Q.** Do you think it would have made a difference if there  
10 had been an acknowledgement?

11 **A.** I think just that acknowledgement and that recognition  
12 at the top level of what was being done deliberately to  
13 children and young people, knowingly and wantonly,  
14 recognising all of the harm that it was doing -- and  
15 there's a whole list of indirect harms that were done --  
16 would it have made a difference? I certainly don't  
17 think it would have made any harm.

18 **Q.** No. Right. I think you do set out in your statement  
19 some of the work the college did --

20 **A.** Yeah.

21 **Q.** -- and in particular the RCPCH &Us programme. Can you  
22 just briefly summarise what that programme is for us?

23 **A.** That's our group of hugely energetic enthusiastic youth  
24 workers who go up and down the country to capture the  
25 voice of young people, to work with young people, to

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1 help young people provide a voice to the college and to  
2 other external stakeholders.

3 **Q.** Right. And at your paragraph 43, you give a number of  
4 examples of key projects that the college --

5 **A.** Yeah.

6 **Q.** -- was involved in. There was 360 children and young  
7 people engaged by the college sharing their challenges,  
8 concerns, hopes and ideas. I understand that. There  
9 was also 74,000 children and young people's voices that  
10 were peer reviewed by the college in relation to themes  
11 relating to lockdown.

12 **A.** Mm-hm.

13 **Q.** Now, I understand that, Professor, but are you able to  
14 be help with any themes in relation to healthcare,  
15 either access of or provision of, rather than the  
16 broader harms that lockdown brought to children and  
17 young people?

18 **A.** I'll try to summarise 72,000 voices. So I think you can  
19 break them down into two. There's children who didn't  
20 have health problems going into the pandemic and  
21 children who already had health problems. So if I do  
22 those in reverse order, I think that there were  
23 anxieties about children who had asthma, epilepsy,  
24 diabetes. About, you know, who is there for them? They  
25 can't get in touch with their usual clinicians or, if

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1 increase awareness of children to the wider society, to  
2 the wider healthcare system as it was being reorganised,  
3 to keep children -- and the aim to get children and  
4 people in the centre of the vision, because our concern  
5 was that children were barely on the periphery of the  
6 vision of the government.

7 **Q.** Turning to some of those impacts, we know that staff  
8 were redeployed from paediatric settings to help care  
9 for adult Covid-19 patients.

10 **A.** Mm-hm.

11 **Q.** And I think the college agrees and acknowledges that the  
12 impact was particularly felt on children from deprived  
13 backgrounds who already had worse health outcomes, and  
14 her Ladyship has already heard about that. But is it  
15 right that the college conducted two projects during the  
16 pandemic to look at, perhaps, why there was drops in  
17 paediatric attendance in acute and, indeed, in community  
18 settings?

19 **A.** We did two surveys.

20 **Q.** Two surveys, yes?

21 **A.** We did one early on and then one over the Christmas of  
22 2021, yes.

23 **Q.** Can I ask you about those? And if it helps you, it's  
24 paragraph 18 onwards in your statement. But I think  
25 perhaps if we have up on screen, please, a summary of

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1 they do, it's difficult. So they were one set of  
2 anxieties around healthcare.

3 And then, as you mentioned before, there were  
4 children who didn't have healthcare problems, mental  
5 healthcare problems, before Covid, but these emerged.  
6 And this -- you know, there were -- there was, you know,  
7 stories of people feeling lonely, anxious, and these  
8 were captured. There are many, many themes that were  
9 captured. But there were mostly themes of isolation,  
10 sadness and need. I don't think there were any warm,  
11 satisfying themes that came out.

12 **Q.** No. You mentioned there particularly mental health care  
13 problems, and her Ladyship is very familiar with the  
14 rise in demand for CAMHS services, to use the acronym,  
15 and other similar mental health services.

16 And I think in September 2021, is it right that the  
17 college made a number of recommendations to the Health  
18 and Social Care Select Committee, which included  
19 ring-fenced funding for children and adolescent mental  
20 health services, and also asked for an overarching child  
21 health strategy?

22 **A.** Mm-hm.

23 **Q.** Can I ask, why was it the college was so keen for there  
24 to be an overarching child health strategy?

25 **A.** I think this goes back to what I was saying before. To

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1 some of the consequences of lockdown before I come to  
2 the service.

3 Can I have up on screen, please, INQ000620599\_1.

4 This just looks at some of the unintended  
5 consequences, and then we will look at the findings of  
6 the surveys themselves.

7 **A.** Yeah.

8 **Q.** And if we go to the middle of the page, the paragraph  
9 beginning "These benefits", you say:

10 "The benefits ... are overshadowed by the negative  
11 consequences of ... lockdown. First and foremost is the  
12 direct impact ... Emergency departments in the UK  
13 experienced unprecedented reductions of [greater than]  
14 50% in attendance ... In Scotland, children's emergency  
15 department attendances fell proportionately more than  
16 any other age-group. This raises concerns that children  
17 with critical illnesses were not accessing health  
18 services on time and, therefore, suffering potentially  
19 avoidable harm."

20 Do you know if the position was the same in Wales  
21 and Northern Ireland?

22 **A.** I imagine it was, but I don't have any confirmed  
23 evidence.

24 **Q.** All right.

25 And if we just go to the next paragraph:

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1 "At the end of April 2020, [there was] a snapshot  
 2 survey of more than 4,000 paediatricians across the UK  
 3 and Ireland ..."  
 4 And 60% of those who responded had witnessed delayed  
 5 presentations, particularly in responses revealing --  
 6 was it delayed presentations in diabetes, children with  
 7 diabetes?  
 8 **A.** Yes, yes.  
 9 **Q.** And delayed presentations of sepsis and new cancer  
 10 diagnoses, and indeed:  
 11 "There were ... nine deaths, resulting mainly from  
 12 sepsis and malignancy, where delayed presentation was  
 13 considered by the reporting paediatrician to be  
 14 a significant contributing factor -- higher than the  
 15 total number of childhood covid-19 deaths reported over  
 16 the same period in England."  
 17 **A.** Mm-hm.  
 18 **Q.** It's not easy to understand why there was the delayed  
 19 presentation, but I think, at the bottom of that page,  
 20 there are potential reasons given for it.  
 21 **A.** Yeah.  
 22 **Q.** Including: parents strictly adhering to the 'Stay at  
 23 Home' messaging, parental concerns about getting Covid  
 24 in hospital --  
 25 **A.** Mm-hm.

81

1 observations that diabetes outcomes were much worse  
 2 during that year. But it's not obviously due to delayed  
 3 presentations.  
 4 **Q.** Right. I won't put it up on screen but I think the  
 5 paper that we're looking at there goes on to be  
 6 concerned about lack of referrals for child protection  
 7 assessments.  
 8 **A.** Yes.  
 9 **Q.** I think also you are -- have seen there were concerns  
 10 about reductions in cancer referrals, in particular NHSE  
 11 has data on that.  
 12 **A.** Yes.  
 13 **Q.** And delays in presentations in child protection cases.  
 14 **A.** Mm-hm.  
 15 **Q.** So health impacts, societal impacts, developmental --  
 16 **A.** Yeah.  
 17 **Q.** -- and, indeed, child protection impacts.  
 18 Now, the reasons for those delays, as we look, may  
 19 be myriad, but certainly from the perspective of the  
 20 college, the two surveys that were conducted, one of the  
 21 concerns was about the impact of redeployment of  
 22 paediatric healthcare staff.  
 23 **A.** Yes.  
 24 **Q.** And the loss of paediatric inpatient space?  
 25 **A.** Yeah.

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1 **Q.** -- not wanting to disturb doctors during the pandemic as  
 2 well, and perhaps any combination of those reasons.  
 3 **A.** Yes.  
 4 **Q.** Do you think the 'Stay at Home' messaging, for people  
 5 who urgently needed healthcare provision, got the  
 6 balance right?  
 7 **A.** So, bearing in mind this was in the fairly early days of  
 8 the pandemic.  
 9 **Q.** Yeah.  
 10 **A.** So this March, April, May time. I have the benefit of  
 11 being able to look back at whole population data over  
 12 that period. So I think the short answer to your  
 13 question is that probably the 'Stay at Home' message was  
 14 not wrong. So when you look at diabetes, which is --  
 15 many people know, is a problem with insulin, it can be  
 16 very sick -- very life threatening, what we know during  
 17 the pandemic year of -- starting March 2020 through to  
 18 February 2021, is that there were, for reasons nobody  
 19 really understands, more new cases of diabetes, and they  
 20 were more likely to present in a more serious way, so  
 21 twice as many would need to go to intensive care, but  
 22 interestingly, and research has looked at time for  
 23 symptoms, and there was no major increase in delay that  
 24 might have explained that.

25 So there's no doubt that time confirms these initial

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1 **Q.** And how, indeed, we would recover once there had been  
 2 the suspension of elective care.  
 3 **A.** Yeah.  
 4 **Q.** And if I look, please, and ask for your paragraph 21 to  
 5 be called up on screen, we can see there the main  
 6 findings of the first phase of the project, which ran  
 7 from April, July 2020.  
 8 **A.** Mm-hm.  
 9 **Q.** There's about 10% of staff not available to work because  
 10 they may have been shielding. Understood.  
 11 **A.** Yeah.  
 12 **Q.** Other staff working in different ways, remote working.  
 13 But up to 40 -- sorry, 46% of community trainees were  
 14 redeployed to acute paediatric care.  
 15 **A.** Mm-hm.  
 16 **Q.** And by the end of the data collection period, 10% were  
 17 still not working in community settings.  
 18 "[It's] worrying because of the importance of  
 19 community services for vulnerable children, and the  
 20 backlog of work such as child protection medicals."  
 21 Redeployment is a tricky issue.  
 22 **A.** Mm-hm.  
 23 **Q.** And can I ask, generally speaking, did the college agree  
 24 with the initial decision to redeploy paediatric  
 25 healthcare professionals -- or did they not disagree

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1 with it, might be a better way of putting it?

2 **A.** Yes, I wouldn't like you to think that we had the  
3 choice. And I think, going back to what I said at the  
4 start, we had to make some very pragmatic decisions as  
5 a society back in March 2020. So I think I wouldn't  
6 disagree with it.

7 I'll just leave that hanging because I'm sure  
8 there's a question coming from you.

9 **Q.** "Paediatric inpatient space lost to adult services was  
10 small but important ... with reported issues getting  
11 [the] space back."

12 Are you able to say or give us an idea of how long  
13 there were issues with -- obviously it was handed over  
14 to adult inpatient, but how long were these issues with  
15 getting it back persisting for?

16 **A.** Months, in some instances. And relatively small, but  
17 the loss of community space was much greater and much  
18 more prolonged.

19 **Q.** Did the college take any steps to try to raise this as  
20 an issue, or lobby?

21 **A.** We highlighted the survey. You'll imagine that the  
22 atmosphere was very noisy at the time, so -- so we did  
23 highlight this. And, as I'm sure we'll come on to, we  
24 repeat the survey later on that year.

25 **Q.** Yes. Well, let's have a look at that, please. If we  
85

1 in wave 1.

2 **A.** Mm-hm.

3 **Q.** And I just wondered whether you had any observations to  
4 make on whether the fact that there was needed to be  
5 this redeployment of staff was because there was any  
6 failure to plan for winter 2020 or 2021?

7 **A.** I'm not really in a position to comment knowledgeably  
8 beyond that.

9 **Q.** All right. I think you also go on to say that there  
10 were paediatric intensive care units that were affected.

11 **A.** Yes.

12 **Q.** And seven out of 23 paediatric intensive care units were  
13 repurposed for adult services, which had a neighbouring  
14 impact on their local other paediatric units who had to  
15 sort of take up the slack, if I may put it colloquially?

16 **A.** Absolutely.

17 **Q.** Do you know, Professor, whether there was any impact on  
18 the care provided to children who needed intensive care  
19 by the fact that some of those services that have now  
20 been repurposed to look after adults?

21 **A.** No, because I think the issue was that it was the  
22 paediatric trained staff who were then looking after  
23 adults. So I think the people looking after children  
24 were appropriately trained and experienced, but if I may  
25 also say, this obviously had impact for time-critical  
87

1 have on screen paragraph 23, because the survey was  
2 conducted, I think, later that year.

3 Here we are, thank you.

4 **A.** Yeah.

5 **Q.** The survey started at the very end of November, right  
6 the way through to February 2021. And we can see there  
7 that the key findings from the survey included 30% of  
8 services had redeployed paediatric trainees to adult  
9 services at the peak in mid-January 2021, and 13% of  
10 services reported that consultants had been redeployed  
11 to adult services at the peak in late January 2021,  
12 which in fact was -- do I take it that was worse than  
13 those that had been redeployed during the first wave?

14 **A.** Yeah, I -- yeah. It wasn't mentioned, so I don't think  
15 there were many consultants redeployed earlier on that  
16 year.

17 **Q.** Right.

18 **A.** Yes, and the implication of that is that it left holes  
19 in rotas, it left holes -- it left trainees being  
20 untrained, and it meant that lots of things that should  
21 have happened in a scheduled context didn't take place.

22 **Q.** The Inquiry is aware that in fact there were more adult  
23 inpatients in hospital in wave 2 over the winter of  
24 2021, in particular January -- sorry, winter 2020 to  
25 2021 -- and in particular January 2021, than there were  
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1 surgery, heart operations. So as with all these things,  
2 there were many indirect implications.

3 **Q.** And I think generally, the impacts of either the  
4 redeployment, the pausing of community health services  
5 and elective care and, indeed, some of the changes to  
6 the amount of the estate that was given over to adults,  
7 all has generally interrupted community care for  
8 children and young people meaning waiting lists are  
9 climbing; is that correct?

10 **A.** That is correct. They are --

11 **Q.** All right. Now, I had a look at some of those with the  
12 witness that preceded you --

13 **A.** Yes.

14 **Q.** -- but can I ask you, please, about the current position  
15 and have on screen, please, INQ000620603.

16 So we saw with the Chief Nursing Officer that they  
17 had begun to rise by the end of 2024, and to bring this  
18 more up to date, there is a Royal College news report  
19 from May 2025 which shows that new analysis as of March  
20 this year, "there were over 314,000 children waiting for  
21 essential community health service. Shockingly, this  
22 figure represents a rise from February to March, meaning  
23 a further 16,000 children are waiting for vital  
24 treatment."

25 A more sort of -- with those sobering statistics in  
88

1 mind, can you help at all as to why the college thinks  
2 that recovery of elective care for children was slow and  
3 slower than it was for adults, as we heard from  
4 Mr Burton?

5 **A.** I think it probably boils down to priority. I think  
6 that children coming into the pandemic were of  
7 relatively low priority, relative to adults. During the  
8 pandemic, I think that gap widened, and I think they  
9 became the lowest of priorities. And I think coming out  
10 of the pandemic, the priority for recovery, for  
11 restoration of normal services again didn't focus on  
12 children. Children were second or third rate.

13 I think what's also important to point out is that  
14 the child health workforce, and I'm here talking about  
15 paediatricians but I'm talking about the wider workforce  
16 that looks after children in the community and in  
17 hospitals, it was a really difficult time. People had  
18 to work in -- there was a lot of friction. They were  
19 expected to do things they weren't trained to do. They  
20 were put in situations that really frustrated them and  
21 if you look at, you know, the January 2021 census, 15%  
22 of the paediatric people responses, they had colleagues  
23 who were off with stress.

24 So I think that the friction, the emotional turmoil  
25 of going through all of this impacted on the workforce

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1 experience, which was very much collected, was used, and  
2 was used as part of an impact assessment that perhaps,  
3 come June 2020, people say, "Okay, right, that was  
4 a stormy three months. What have we learnt for  
5 children? What have we done to children? What harm are  
6 we doing to children? And what should we do to redress  
7 this?"

8 And I see very little evidence of that ever  
9 happening, and the evidence is that come the second  
10 lockdown at Christmas '20, the same thing was done.  
11 Even though we knew that children, mercifully, were  
12 spared from the harm that came from Covid, even my most  
13 sick patients, when they and their family got Covid, it  
14 was the parents who were unwell. These vulnerable  
15 children were remarkably unaffected.

16 We knew that mental health was going up, we'd seen  
17 so many young people coming in with anorexia, we knew we  
18 were doing loads of harm and yet we did exactly the same  
19 thing when the second wave came.

20 **Q.** I wanted to ask you about the mental health impacts  
21 because you say in your statement that although the  
22 college doesn't have strict involvement with CAMHS, it  
23 does play an advocacy role in relation to child and  
24 adolescent mental health services, and indeed, there was  
25 unprecedented demand on CAMHS, and you say:

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1 and, again, I think this is across the whole of the  
2 sector. And I think that is also going to be part of  
3 why we are in the pickle that we are at the moment.

4 **Q.** Right. And that would echo with evidence her Ladyship  
5 has heard in other modules, I have no doubt.

6 But can I perhaps come back to something we started  
7 with and your paragraph 27, please, Professor, and you  
8 said this:

9 "The College recognises that necessity meant that  
10 services had to be reconfigured or paused, including the  
11 redeployment of child health professionals to adult  
12 services and recognises this was the right thing to do  
13 initially."

14 **A.** Yeah.

15 **Q.** I suspect you might emphasise the word "initially"?

16 **A.** Yeah, absolutely.

17 **Q.** But you say:

18 "However, the College was alive to the potential  
19 impact ..."

20 What does the college say about whether thereafter,  
21 once the eye of the storm, if I may put it like that,  
22 had passed, what focus was given to helping health care  
23 for children and young people to recover?

24 **A.** So what might have happened in an alternative parallel  
25 universe is that evidence which was collected was used,

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1 "In turn, it resulted in an increase in children and  
2 young people presenting to emergency departments with  
3 complex psychosocial crises."

4 And I think it was in December of 2021 that the  
5 Royal College, along with the Royal College of Emergency  
6 Medicine and the Royal College of Psychiatrists put out  
7 a joint statement, and I'd just like to look at that  
8 statement.

9 Can we have up on screen, please, INQ000620625.  
10 Thank you very much.

11 You can see there that the background is setting out  
12 the enormous toll that the pandemic has taken on the  
13 mental health of children and young people across the  
14 country. You make the point there that it's struggling  
15 to keep up with demand. Obviously there was  
16 a pre-existing mental health crisis for children, and if  
17 we go down, please, in the page, to what your college  
18 and your fellow contributors to this statement are  
19 doing:

20 "Proactively engaging with NHS leaders working to  
21 improve systems."

22 May I just ask you, are you able to give a little  
23 bit of detail about what is there quite a bald or bland  
24 statement?

25 **A.** We were doing as best we can providing data to senior

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1 decision makers across the four nations. Whether we  
 2 were heard, I will ...  
 3 **Q.** All right.  
 4 **A.** Yeah, the evidence is that we weren't.  
 5 **Q.** "Emphasising the importance of expanding paediatric  
 6 liaison and CAMHS across the UK, to achieve 24/7 access  
 7 to support for children and young people and improving  
 8 access to appropriate inpatient provision."  
 9 Can you provide a little detail or colour to that?  
 10 **A.** So if you look at adults, adults have inpatient mental  
 11 health facilities for adults who have acute mental  
 12 health problems. Children don't. I live in Aberdeen,  
 13 the nearest inpatient facility is in the central belt of  
 14 Glasgow, 100 miles away. So there is no 24/7, there is  
 15 very limited 24/7 response.  
 16 So if a child with autism, for example,  
 17 decompensates at home and the family are unable to cope  
 18 with a violent, very agitated young person, they call an  
 19 ambulance, the child is brought to the emergency  
 20 department. Well, that's not right for the child, it's  
 21 not right for the other children in the emergency  
 22 department but we just as a society have no  
 23 consideration for what might happen out of hours with  
 24 children's acute mental health.  
 25 **Q.** And you call for mental health leadership across

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1 **A.** Well, I guess if it's done because of local need,  
 2 I think that's a very reasonable thing. I think if it's  
 3 done differently because of local resources, that's not  
 4 a good thing. It's a question of whether the service  
 5 has been fitted around the child or whether the child is  
 6 having to fit around the service.  
 7 **Q.** I think you welcomed the news in 2023 that there would  
 8 be a mental health champion in every provider that  
 9 admits children.  
 10 **A.** Yeah.  
 11 **Q.** Can you help or expand on what the role of the mental  
 12 health champion is or does?  
 13 **A.** Yes, thanks. This worked really well. So we recognised  
 14 that there was a huge rise in children presenting with  
 15 mental health conditions, eating disorders, anorexia was  
 16 the trigger. And we recognised that if we identified  
 17 a clinician in each hospital who would take a lead for  
 18 that, because as a paediatrician, I've never been  
 19 trained in mental health but it's sort of been forced  
 20 upon me and some of my colleagues have taken extra  
 21 training. And if we identify people who are able to  
 22 manage these complicated young people and their  
 23 families, work with the community, work with the mental  
 24 health services, perhaps, not surprisingly, things go  
 25 a lot better. And so there were lots of paediatricians

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1 departments to be strengthened. The recruitment of  
 2 staff able to bridge the gap between services and  
 3 accelerating the rollout of integrated models of care.  
 4 **A.** Yeah.  
 5 **Q.** Again, same question: are you able to give us a little  
 6 bit more detail about what the Royal College was doing  
 7 in relation to that bullet point?  
 8 **A.** Well, what we were and what we continue to point out is  
 9 that mental health problems are usually detectable many  
 10 weeks and months before they happen, and if we can  
 11 intervene, if we can identify, and get involvement with  
 12 a child and their family earlier on, many of these  
 13 admissions can be avoided. We continue to push this  
 14 message, because the message still needs to be heard.  
 15 **Q.** You say in your statement that there has been some  
 16 progress made in relation to supporting the mental  
 17 health needs of children and young people and you point  
 18 to some work done by NHS England in 2022 when they  
 19 published a framework setting out how children and young  
 20 people with mental health needs in acute paediatric  
 21 settings could be dealt with. And you say, though, the  
 22 framework has been implemented differently in different  
 23 areas.  
 24 **A.** Mm.  
 25 **Q.** Is that necessarily a bad thing or a good thing?

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1 who saw this as a step forward and it worked really  
 2 well, but inevitably, once it was up and established,  
 3 there were challenges to it. So funding was questioned,  
 4 succession planning was questioned, and inevitably,  
 5 their inbox became a lot bigger with lots of other  
 6 mental health problems coming through.  
 7 So they did work really well, but they could work  
 8 even better.  
 9 **Q.** Right. More generally, I think you say the college was  
 10 vocal, to use your words, on safeguarding issues during  
 11 lockdown, and there was concern that the needs of  
 12 vulnerable children were not being met. And I think the  
 13 college made clear the importance of safeguarding, in  
 14 particular noting the role that schools play in  
 15 identifying children who may be vulnerable or subject to  
 16 neglect or abuse and the like.  
 17 **A.** Yeah.  
 18 **Q.** And does the RCPCH have a view on whether it was right  
 19 to close the schools?  
 20 **A.** Again, initially, I think it made sense. But when you  
 21 recognise that 30% of children in the UK, wherever you  
 22 are, were living in poverty, and their school meal is  
 23 the only good food they'll get all day, there are  
 24 obvious problems there.  
 25 You've talked about safeguarding. You're going to

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1 hear from my colleague from the Institute of Health  
 2 Visiting later on, you know, there are bad things that  
 3 happen behind doors within families, and when everybody  
 4 is staying at home in lockdown and social workers aren't  
 5 able to get into people's homes, those bad things aren't  
 6 going to stop happening. And I would argue that if  
 7 you've got everybody locked up in the same house, the  
 8 things that trigger violence and abuse to children are  
 9 probably going to be worse.

10 So there were loads of concerns from the  
 11 safeguarding perspective about closing schools, and  
 12 basically locking families away. And that's  
 13 notwithstanding all of the educational, societal and all  
 14 of the other impacts of stopping -- of shutting schools.

15 **Q.** May I ask you about a different aspect of vulnerability  
 16 in children, and, in particular, the college's  
 17 involvement in advice on children who were in the  
 18 shielding programme.

19 **A.** Yes.

20 **Q.** Can you help, and it's at paragraph 33 of your  
 21 statement, Professor, but I think you say there that the  
 22 college was pleased that the UK Government adopted the  
 23 college's advice on shielding for babies, children and  
 24 young people, recommending that most, but not all,  
 25 children and young people did not need to shield.

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1 a lot of friction. So when the changes were brought  
 2 through on behalf of our parents, families, you know, we  
 3 thought this was great news. And it was really good  
 4 that the government did listen.

5 So, going back to your very first question, that was  
 6 perhaps one good thing that did happen during the  
 7 pandemic. I got one.

8 **Q.** I think, though, there was still nonetheless a small  
 9 group of children that were deemed so clinically  
 10 extremely vulnerable that they did have to continue to  
 11 shield?

12 **A.** There was a very small number. And that was done on  
 13 a case-by-case basis.

14 **Q.** Right. You may be asked some further questions about  
 15 clinically vulnerable children in a moment.

16 May I just take a pause and a stand back, please,  
 17 and just a final few reflections and, indeed,  
 18 recommendations from you. Really this, if it's not  
 19 already obvious, but the college's overriding message,  
 20 as set out in your statement, is that pandemic planning  
 21 cannot simply deal with people who become most unwell  
 22 with the virus, which in this case was mostly adults.

23 "As the future generation, babies, children and  
 24 young people, regardless of the direct impact on this  
 25 group, must be prioritised."

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1 **A.** Yeah.

2 **Q.** Why was that welcome news from the college's  
 3 perspective?

4 **A.** So, again, when we started, we thought this could be  
 5 really nasty, and there were -- there were three  
 6 categories into which people of all ages were placed in  
 7 terms of risk, but very, very, very, very quickly, our  
 8 patients and their parents told us that if -- as  
 9 I mentioned before, children who have gone through  
 10 heroic of surgery or life-threatening problems, are  
 11 ventilated at night, when they get Covid, and the rest  
 12 of the family gets Covid, it's the parents and the  
 13 carers who are -- so we knew very early on that they,  
 14 for whatever reason, weren't affected. Children who  
 15 have had kidney transplants, whose immune system was  
 16 suppressed, we were really worried about them, but the  
 17 virus bounced off them.

18 So we knew very, very quickly that this virus, for  
 19 whatever reason, was not doing harm for the vast  
 20 majority of children in whom we thought it would be, and  
 21 it was also causing huge anxiety for their parents. You  
 22 know, "Do I keep my child whose had the kidney  
 23 transplant in a separate room to all of the rest of the  
 24 other family? What do I do?"

25 So we knew that, domestically, this was causing

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1 You will have heard me asking the Chief Nursing  
 2 Officer about a number of potential pieces of evidence  
 3 to suggest that there wasn't the priority placed on  
 4 children. The reasons for it may be difficult to  
 5 ascertain, but can you help, from the college's  
 6 perspective, why it was that there was this focus on  
 7 adults primarily, and particularly not, then, focusing  
 8 on the indirect harms to children and young people?

9 **A.** Yeah, I'm in danger of repeating myself. I think at the  
 10 start it was very reasonable to do what was done. But  
 11 we very quickly had knowledge, data, experience, that  
 12 children not being directly affected by the virus but  
 13 were being hugely, and in some cases irretrievably,  
 14 damaged by the indirect consequences of what we were  
 15 doing to them.

16 I think that the message I would be keen to get  
 17 across is that there was -- before the pandemic, during  
 18 the pandemic and after the pandemic, there has not been  
 19 equity. Children are not treated equally in our  
 20 society. It is a defining characteristic against which  
 21 we should not prejudice, but children do not get the  
 22 best in this country. They're 25% of the population and  
 23 get 11% of the NHS spend. They rarely ever seem to  
 24 feature in decision making. I think that senior  
 25 decision makers acknowledge children, but -- but they

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1 don't seem to get it. And the "it" is that, first of  
2 all, children don't undergo an epiphany when they reach  
3 adulthood. All of their health and illness issues  
4 aren't -- they're not just taken away. They carry on.  
5 And the economic impact is vast.

6 You know, the Nobel Prize was awarded in 2020 -- in  
7 2000 to the guy who demonstrated that if you invest in  
8 children, the benefits to society are clear and evident.  
9 But that economic, that rights, and that equality  
10 argument for looking after children just doesn't get  
11 recognised in any of the four nations in the UK.

12 So, going back to your question, why were children  
13 not prioritised, I think it goes back to that. I think  
14 that, for whatever reason, people didn't think -- I'm  
15 not going to say that people didn't think that they were  
16 worth it, but people just didn't realise the harm they  
17 were doing, despite organisations, including ours,  
18 saying: This is wrong, you cannot carry on doing this.

19 **Q.** In your statement, the college sets out  
20 12 recommendations for how to potentially prepare for  
21 a future pandemic. I'm not going to ask you about all  
22 12, Professor, but one of the recommendations you make  
23 is that there is a comprehensive paediatric pandemic  
24 preparedness assessment --

25 **A.** Yes.

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1 being having to make some very, very difficult  
2 decisions. And I understand that, to continue with the  
3 alliteration, it's Project Pegasus that has been looking  
4 at that, that has been looking at that today.

5 But I think we can plan, but the planning that takes  
6 place on a whole-population basis needs to have right at  
7 its heart, 'Don't forget the children'.

8 **Q.** Right. Which brings me to my final topic for you and  
9 it's your recommendation at paragraph 49.3, and you  
10 recommend on behalf of the college:

11 "That regular children's rights impact assessments  
12 should be carried out and published to accompany all  
13 policy decisions or legislation changes which impact  
14 them."

15 Can you help us, please, what benefits do you think  
16 such an approach would have on children's health in the  
17 UK, were there children's rights impact assessments, as  
18 you set out in your statement?

19 **A.** Yeah, I think it would help people think "child".  
20 I think it would remind people not to forget children.  
21 Children do have rights, and these need to be considered  
22 in amongst the rights of the rest of the population. So  
23 I think that they would very much help people in senior  
24 decision-making places to think "child".

25 **MS CAREY:** That may be a good place to stop.

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1 **Q.** -- that is undertaken, which will consider staffing,  
2 spaces, systems, equipment, ICU provision and the like.  
3 What difference do you think that would make in the  
4 event of a future pandemic, assuming it's one that  
5 affects adults still, primarily?

6 **A.** Yeah, so I think there's a number of different  
7 considerations. So if there was a pandemic -- if -- had  
8 the Covid pandemic affected children equally as it had  
9 the adults, thousands of children would likely have  
10 died, because we just did not have the resource to  
11 provide intensive care on that scale.

12 I think if another pandemic was like Covid, and very  
13 much affected the elderly, I still think we need to  
14 preserve services. I think, learning from what we have  
15 done, we need to recognise that the indirect harms of  
16 shutting down community services, shutting schools, many  
17 years down the line will be leaving ripples of  
18 discontent, poor development and harm.

19 And I think if the next pandemic, because I think  
20 it's a matter of time, hopefully a long time, if that  
21 affects children more than adults, then I think we are  
22 in a real problem, because we do not have the workforce  
23 to look after children now, so if we had an expanded  
24 population of ill children with this -- with a virus,  
25 I think we would be in a very, very difficult place and

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1 Professor, they are all my questions but there are  
2 some questions from Mr Wagner King's Counsel on behalf  
3 of the Clinically Vulnerable Families. He's just over  
4 there, we'll just pause one moment while we turn to him.

5 **THE WITNESS:** All right. Okay.

6 **LADY HALLETT:** Thank you, Ms Carey.

7 Mr Wagner.

#### 8 Questions from MR WAGNER KC

9 **MR WAGNER:** Good afternoon.

10 **A.** Good afternoon.

11 **Q.** As Ms Carey said, I represent the Clinically Vulnerable  
12 Families, which is a group, as you can probably guess,  
13 that represents the interests of clinically vulnerable,  
14 clinically extremely vulnerable and immunocompromised  
15 children and families.

16 I just want to ask you first about the guidance or  
17 advice that you published in June 2020 that you were  
18 taken to, or you were asked about by Ms Carey, and then  
19 was adopted by the Department of Health in July 2020.

20 The guidance said, one of the things it said, was  
21 that the majority of children with asthma, diabetes,  
22 epilepsy and kidney disease do not need to continue to  
23 shield and could, for example, return to schools as they  
24 reopened.

25 You're aware of the guidance, and I don't --

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1 A. Yeah.

2 Q. -- and you don't need to go to it.

3 Did you appreciate that children with asthma,

4 diabetes, epilepsy and kidney disease were not actually

5 shielded at that time, had not been told to shield?

6 A. I understood that they had been told to shield, which is

7 why the guidelines said that they did not need to

8 shield.

9 Q. Yeah. So -- they weren't told formally to shield in the

10 way that adults were. On reflection would you accept

11 the guidance in that respect was a bit muddled?

12 A. So I do a lot of asthma clinics, and my parents were

13 telling me that they were shielding their children.

14 I think that the message "you should shield if you've

15 got asthma" had got out there, and it might well have

16 been a bit muddled, if the initial message was just for

17 adults with asthma to shield, but certainly my

18 experience is that children with asthma were being

19 shielded, with some difficulty, and they were delighted

20 that they were no longer -- they were told they no

21 longer needed to shield.

22 Q. But you accept that may have been coming from individual

23 decisions taken by parents rather than formal government

24 advice?

25 A. Yes, and I stand corrected. I understood that the

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1 accept there might have been some and there certainly

2 were some.

3 Q. And do you also accept that at that time, in June,

4 July 2020, schools were, in terms of Covid transmission,

5 still risky environments, particularly because of

6 crowded classrooms, poor ventilation, prolonged indoor

7 contact, and the lack of masking?

8 A. I'm -- well, so, take that -- I think a lot of schools

9 demonstrated some social distancing. I think some

10 schools insisted children wore masks beyond the summer

11 of 2020. But I do accept the premise that if you put

12 people together, infections do spread.

13 What I don't accept is that for a healthy child,

14 getting Covid put them at considerable risk, that that

15 meant, from the child's perspective, that they shouldn't

16 go to school.

17 Q. But for the child who had that additional risk, even if

18 it was just a bit more risk, and that's -- my client's

19 perspective is from that perspective --

20 A. Sure.

21 Q. -- do you accept that for some parents, even knowing how

22 important in-person schooling is, and all of the factors

23 you've rightly pointed out, it would have still been

24 reasonable for them, making that individual risk

25 analysis, to decide that in-person schooling was not the

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1 original advice that was given to children with asthma,

2 diabetes, epilepsy, was to shield, because at that time

3 we thought that they might be vulnerable, but I was

4 pleased that in the summer of 2020, that it was

5 clarified that they did not need to shield. So I think

6 that did clarify the situation.

7 Q. I appreciate, listening to your evidence, that your

8 focus was on -- correct me if I'm wrong -- it was on

9 encouraging children who didn't have a higher risk and

10 parents who may have thought their children had a higher

11 risk to return to school because it was better for them

12 to be at school than not to be at school.

13 Do you accept that there were, nonetheless, children

14 with certain conditions such as chronic kidney disease

15 and diabetes who had higher risks from Covid-19 than the

16 general population?

17 A. I'm sorry, I didn't catch your question.

18 Q. So do you accept that there were certain conditions such

19 as chronic kidney disease and diabetes --

20 A. I see, sorry. Right. I accept that there were some

21 children who might be more vulnerable than others. My

22 personal experience is that there were vanishingly few

23 of them, but no, and that's why I think the guidance was

24 that there might be some children who do need to shield

25 and that is very much on a case-by-case basis. So I do

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1 correct option for their children because they didn't

2 want to put them to that additional risk?

3 A. I think that for the vast, vast, vast, vast, majority of

4 children with the conditions that we talked about,

5 diabetes, asthma, there was -- the individual child was

6 at no increased risk -- of no meaningful increased risk

7 for coming to any harm from Covid, and it was very much

8 in their benefit that they got back to school.

9 Q. And just finally, do you think, looking back, that the

10 college's guidance properly reflected that there were

11 some children for whom the risk would have been higher,

12 and the decision making -- the factors may have been

13 just a bit different for them?

14 A. I can't remember the exact words of the college guidance

15 but I think the spirit of the college guidance was

16 exactly right: that the vast majority of children who

17 were initially thought to have some increased risk

18 didn't actually have that risk, but I also accept that

19 there were some children who were potentially at risk.

20 But that number was tiny.

21 MR WAGNER: Thank you.

22 LADY HALLETT: Thank you very much indeed, Mr Wagner.

23 That completes the questions that we have for you,

24 Professor Turner. Thank you very much for the help that

25 you've given to the Inquiry. I don't know if any

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1 colleagues assisted you, but thank you for what you've  
2 done, and if they did, thank you to them as well. Thank  
3 you for helping us.

4 **MS CAREY:** Thank you, my Lady.

5 **THE WITNESS:** You're very welcome.

6 **LADY HALLETT:** Very well, I shall return for this  
7 afternoon's session at 1.45.

8 **MS CAREY:** Thank you very much.

9 (12.44 pm)

(The Short Adjournment)

11 (1.44 pm)

12 **MS POTTLE:** Good afternoon my Lady. Can you see and hear  
13 us?

14 **LADY HALLETT:** I can, thank you, Ms Pottle. Thank you very  
15 much.

16 **MS POTTLE:** This afternoon, my Lady, we're going to hear  
17 from three witnesses, the first of which is  
18 Claire Dorer. Please can the witness be sworn.

19 **MS CLAIRE DORER OBE (affirmed)**

20 **Questions from COUNSEL TO THE INQUIRY**

21 **LADY HALLETT:** Thank you for coming to help us, Ms Dorer.

22 **MS POTTLE:** Ms Dorer, you've provided a helpful witness  
23 statement to the Inquiry. It should be in front of you,  
24 and the reference is INQ000587851.

25 Ms Dorer, you have been the chief executive officer  
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1 schools are not run by local authorities; is that right?

2 **A. (No audible answer)**

3 **Q.** But nevertheless, it is not parents who are usually  
4 playing for placements in your schools, those placements  
5 are purchased by local authorities; is that right?

6 **A.** That's correct.

7 **Q.** Okay. And can you just help us briefly, at a high  
8 level, what the differences are, the main differences,  
9 between your member schools and special schools that are  
10 maintained by local authorities?

11 **A.** Yes. I mean, in registration terms, it is broadly about  
12 level of autonomy. So whilst special academies are  
13 public bodies, they are still autonomous from local  
14 authorities. Non-maintained special schools are  
15 a particular form of charitable independent school, and  
16 independent schools are entirely independent of the  
17 state.

18 **Q.** Okay.

19 **A.** Do you want me to say anything about in practical terms?

20 **Q.** Yes, in practical terms, are the schools bigger or  
21 smaller? Do they have a wide range of students? How  
22 does it work?

23 **A.** Our member schools tend to be smaller than maintained  
24 special schools, so an average size of around 50 to  
25 60 students, whereas quite a high percentage of

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1 of the National Association of Special Schools since  
2 March 2025; is that right?

3 **A.** That's right.

4 **Q.** Can you tell us briefly what the National Association of  
5 Special Schools is.

6 **A.** We are a membership body currently for special schools  
7 which are not maintained by local authorities, and that  
8 means, in practice, independent schools, special  
9 academies and non-maintained special schools.

10 We have a sort of two-pronged function: we exist to  
11 represent schools with central government and other  
12 bodies, and we support schools with advice, guidance and  
13 training.

14 **Q.** And you have over 450 member schools across England and  
15 Wales; is that right?

16 **A.** That's correct.

17 **Q.** And roughly 15,000 placements for children with special  
18 educational needs; is that right?

19 **A.** Yes.

20 **Q.** Okay. In your statement, and you've just told us in  
21 fact that your members include independent schools,  
22 non-maintained special schools, and special academies.  
23 And without going into the detail of those statuses and  
24 the registration requirements and so on, I think it's  
25 right, isn't it, that the main difference is that your

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1 maintained special schools, which cover a very wide  
2 range of special educational needs, our schools tend to  
3 be more specialised, often for autistic learners or  
4 learners with social, emotional and mental health needs,  
5 but also for speech, language and communication needs  
6 and sensory impairments.

7 **Q.** I see. And I think in your statement you say that over  
8 62% of your schools support autistic children?

9 **A.** Yeah.

10 **Q.** And 65% of your schools support those with social,  
11 emotional and mental health needs, and that a small  
12 percentage support children with speech, language and  
13 communication needs, and physical and hearing impairment  
14 needs; is that right?

15 **A.** That's correct.

16 **Q.** Okay. Before I ask you about the impact of the pandemic  
17 on your member schools, I'd like to touch briefly on the  
18 situation in your member schools in March 2020, so just  
19 before, on the eve of the pandemic.

20 What trends did your members observe among special  
21 schools prior to the pandemic? And you deal with this  
22 at paragraph 12 of your statement.

23 **A.** Yes, we'd seen a trend of rising numbers of children  
24 being placed in special schools.

25 **Q.** Can I just ask you to speak up a bit so we can hear you

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1 a bit clearer.

2 **A.** Yes, we'd seen a rising trend of children being placed  
3 in independent schools, and specifically in independent  
4 special schools. So our schools were seeing larger  
5 numbers of children who had joined them with a greater  
6 level of complexity of need, and overlapping needs. So  
7 children would come with autism and mental health needs  
8 as well. It wasn't single categories.

9 And a trend of children having been out of education  
10 for some time, at the point of placement, or having been  
11 through several unsuccessful placements before coming to  
12 their independent or non-maintained school.

13 **Q.** Okay. In your statement you also mention children being  
14 highly disengaged from learning, and having to learn to  
15 trust the adults around them. Could you just elaborate  
16 on that?

17 **A.** We had children who had not been to school for two or  
18 three years before being placed, and had had really very  
19 little learning during that time, believed that school  
20 was somewhere where they went to fail, that there was no  
21 point in them being in school, that they couldn't learn,  
22 that they wouldn't learn, that they would be excluded  
23 for bad behaviour.

24 So there was a huge amount of work that went into  
25 establishing relationships that enabled learning to take

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1 to us.

2 **Q.** Okay. I asked you there about the first lockdown. Was  
3 it any different in the second period, January 2021 and  
4 onwards, was it the same sort of numbers of children  
5 attending?

6 **A.** We saw an increasing number of children attending as we  
7 moved through the pandemic as a whole, and certainly for  
8 the second lockdown, I think attendance was potentially  
9 at a high compared to the third lockdown, where there  
10 were more restrictions that I think limited attendance.

11 **Q.** Okay. In your witness statement you mention the use of  
12 bubbles as an infection control strategy, that that made  
13 it more challenging for high numbers of children to  
14 attend; is that right?

15 **A.** It placed some barriers in the way, or gave schools need  
16 to work around them to ensure that children could  
17 attend, but it did complicate things with the way that  
18 particularly children were transported to school, where  
19 the integrity of bubbles was really difficult to  
20 maintain.

21 **Q.** Okay. And can you just help us, if children are in  
22 a bubble, I suppose the bubble would include a teacher  
23 or a staff member. How practically did that make it  
24 more difficult to have all the students attend the  
25 school? Can you help us with that?

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1 place when those children arrived in school.

2 **Q.** And am I right in thinking, therefore, that those  
3 relationships that the children built with their  
4 teachers, or other staff members at the school, were all  
5 the more important in helping reengage those children in  
6 learning?

7 **A.** They were absolutely vital.

8 **Q.** Okay. I'm going to move on now to the impact of the  
9 pandemic on children and young people who attended your  
10 member schools.

11 Special schools were not required to close during  
12 the lockdown; is that right?

13 **A.** That's correct.

14 **Q.** Okay. I'd like to ask you now about the attendance of  
15 children at your member schools. How many children,  
16 roughly, or what proportion of children, were able to  
17 continue attending member schools?

18 **A.** It is really difficult for me to give an exact figure.  
19 NASS's function isn't to gather data so I'm reliant on  
20 what I was told by member schools when we did snapshot  
21 surveys. It varied across the pandemic, but once we got  
22 through the first element of the first lockdown, we were  
23 hearing reports from some schools who said they had a  
24 hundred per cent of learners in, and an average of  
25 around 75% of learners being in from those who reported

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1 **A.** Can you unpack about the point about having a teacher  
2 there, why that would have made it more difficult? I'm  
3 not quite clear what you're asking.

4 **Q.** Pardon me, I didn't mean to suggest that it would,  
5 necessarily, but in your statement you say that the  
6 introduction of bubbles made it more challenging for  
7 schools to have higher levels of attendance, and I'd  
8 just like to explore with you why that is.

9 **A.** In part, it was about how you get day children into  
10 schools. So children would be reliant on local  
11 authority transport or taxis. So you might think that  
12 a group of children who travel together would naturally  
13 be a bubble once they reach school, but they might have  
14 been of very different ages and needs so practically  
15 they would not then have formed a bubble in the  
16 classroom.

17 You may have had specialist staff who would have to  
18 move between bubbles, so particularly any therapists who  
19 were working in schools, it would have been very  
20 difficult for them to limit to a single bubble, and  
21 where children were residential within the school, you  
22 had to think about residential bubbles versus school  
23 bubbles, whether they would be the same or whether you  
24 would have to look about moving across bubbles.

25 **Q.** Okay. And can you help us with what proportion of your

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1 schools were residential special schools?  
 2 **A.** It's around 40%.  
 3 **Q.** Okay. I'd like to contrast the position in your member  
 4 schools with what the Inquiry has already heard about  
 5 the attendance of children in maintained special  
 6 schools, and I'd like to take you now to a figure set  
 7 out in the Children's Commissioner Report titled  
 8 Childhood in the time of Covid -- thank you very much.  
 9 The reference is INQ000231345. It was published in  
 10 September 2020 and if we could move, please, to page 8,  
 11 we see here a helpful graph setting out the percentage  
 12 of children with an education, health or care plan  
 13 attending school during lockdown.  
 14 So these are maintained schools, and we can see that  
 15 the figure fluctuates between 10% around 23 March, and  
 16 goes all the way down to perhaps 2% by 13 April, and  
 17 overall, the figure up to July is 6% of children with  
 18 EHCPs attended school from the start of lockdown until  
 19 the end of May. So this is attendance for pupils with  
 20 an EHCP attending state-funded education settings,  
 21 including mainstream settings, as well. So it's not  
 22 a direct comparison with your member schools.  
 23 But the figure here seems much lower than the figure  
 24 that you reported to us. Could you give us -- well,  
 25 what you think might be the reasons for higher

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1 than if you were a school who were reliant on those  
 2 health services coming in externally.  
 3 **Q.** I see. And in your statement you say that it was  
 4 recognised that because member schools had the  
 5 facilities and equipment necessary to ensure that those  
 6 schools remained the safest place for their children,  
 7 that led to decisions being made for higher attendance.  
 8 Have I got that right?  
 9 **A.** Particularly where children have complex medical needs  
 10 or health conditions, there's usually a lot of  
 11 specialist equipment that goes with that. And  
 12 particularly where those schools are residential, it was  
 13 felt that schools were going to be best able to provide  
 14 that care, and that that couldn't easily be replicated  
 15 for all families at home.  
 16 **Q.** I see. And if we contrast that with the position of  
 17 maintained schools, do they also employ their own  
 18 therapists, for example occupational therapists or  
 19 speech and language therapists?  
 20 **A.** At the time of the pandemic, that was much less common,  
 21 that usually they would be part of a service level  
 22 agreement with the NHS to buy in a certain amount of  
 23 resource that would come into school.  
 24 **Q.** I see. And your schools would purchase those services  
 25 directly; have I understood that correctly?

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1 attendance rates at your member schools?  
 2 This can come down. Thank you.  
 3 **A.** Yeah, I think that there were a variety of reasons. So  
 4 the starting point of the most vulnerable children being  
 5 those who should be offered a school place during the  
 6 first lockdown would mean that children placed in our  
 7 settings would have likely been the most vulnerable:  
 8 those whose complexity of need or social and family  
 9 circumstances were such that they would have been at  
 10 greatest risk had they not been in school. And our  
 11 schools responded to that.  
 12 I think a second factor is the autonomy that our  
 13 schools had, so it was largely down to head teachers,  
 14 governors, directors, to decide if and how the school  
 15 could remain open, rather than being a smaller part of  
 16 a larger local authority or a multi-academy trust.  
 17 And then I think a big element was who was employed  
 18 directly by the school. So you had your teachers and  
 19 support staff, but, actually, a lot of our schools  
 20 directly employ therapists, speech and language  
 21 therapists, OTs -- occupational therapists -- and mental  
 22 health staff. And if the school was open and other  
 23 staff were coming in, then those staff were coming in as  
 24 well.  
 25 So you had that ability to offer a fuller service

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1 **A.** They would directly employ therapists, so the speech and  
 2 language therapist would be employed by the school and  
 3 not be commissioned from the NHS.  
 4 **Q.** Okay. We heard already in the first week of the  
 5 hearings that children who had an education, health and  
 6 care plan would have to have a risk assessment carried  
 7 out before they could attend school, and that there were  
 8 some difficulties with those risk assessments being  
 9 carried out. For example, a survey showed that some 75%  
 10 of parents of children either thought that the risk  
 11 assessment hadn't been carried out or that they  
 12 certainly weren't aware of one being carried out.  
 13 Were risk assessments carried out for children  
 14 attending your member schools? Was there difficulty  
 15 with that?  
 16 **A.** I'm not able to give you a global position, only as and  
 17 when it was reported to me. My understanding was that  
 18 schools carried them out. I don't know to what level  
 19 parents were involved in all cases. In terms of  
 20 physical involvement of parents, it may depend on how  
 21 far away they lived from school. That might have been  
 22 a practical consideration.  
 23 But in general, yes, risk assessments were carried  
 24 out and continued to be carried out.  
 25 **Q.** Can you help us whether there were children who were not

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1 offered a place at member schools because of the results  
 2 of risk assessments? Do you know, or --  
 3 **A.** I don't know, and I think it would be unwise of me to  
 4 comment when I don't know.  
 5 **Q.** Thank you.  
 6 Did member schools encounter parents who wished to  
 7 keep their children away from school due to clinical  
 8 vulnerability in the household? Are you aware?  
 9 **A.** Yes, but my understanding is in relatively small  
 10 numbers.  
 11 **Q.** And where that was the case, albeit in small numbers,  
 12 can you help us with what the approach of your member  
 13 schools was to those families? Was there a process of  
 14 engagement to encourage the child to attend or was it  
 15 felt that the parents' wishes would be respected? Can  
 16 you help us with that?  
 17 **A.** Again, I think it's difficult for me to speak  
 18 authoritatively for all schools. I had heard of cases  
 19 where staff from the school would go out to try to  
 20 support the child at home where parents were very  
 21 concerned. That was obviously limited by how far away  
 22 from school the family lived, and that could be a long  
 23 distance.  
 24 I also understand that schools were encouraging of  
 25 children coming back, but respectful of parents' wishes

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1 children able to reflect their distress at having their  
 2 routine disrupted.  
 3 **Q.** You mentioned at the beginning of your evidence the  
 4 importance of that relationship between staff and pupils  
 5 at your member schools. And I suppose it perhaps is  
 6 a mixed picture because a lot of students were able to  
 7 continue attending their school, but what did your  
 8 member schools report to you about the disruption to  
 9 those relationships between staff and pupils?  
 10 **A.** Yes, so there were a lot of schools who talked about  
 11 having to treat children almost as if they were  
 12 rejoining -- well, joining school for the first time  
 13 when they came back.  
 14 **Q.** I see.  
 15 **A.** So to take them back to the start of re-establishing the  
 16 relationships, establishing that school was a safe place  
 17 to be, a place where they could learn. And certainly,  
 18 when we got to September 2020, schools were reporting  
 19 that it was almost like having a classroom full of new  
 20 students, even though they were returning students.  
 21 **Q.** I see. How did members feel that the pandemic had  
 22 impacted on children and young people's learning  
 23 specifically? I'm going to come on to ask you a bit  
 24 about the catch-up provision, but if we can just talk  
 25 about the actual learning done by learners in your

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1 ultimately. And I think, in many cases, it was concern  
 2 about the child's clinical vulnerability that meant that  
 3 they remained at home rather than about clinical  
 4 vulnerability within the family.  
 5 **Q.** Okay. Thank you.  
 6 I'd like to ask you now about children and young  
 7 people's wellbeing during the pandemic at your school.  
 8 How did member schools report the impact of the pandemic  
 9 on learners' wellbeing?  
 10 **A.** It was very mixed, and it changed between groups of  
 11 children and at times during the pandemic. So we had  
 12 phases, particularly early on, where there were  
 13 a reduced number of children in schools, reduced demands  
 14 for the curriculum, where schools were reporting with  
 15 some surprise that they were seeing fewer incidences of  
 16 young people being distressed or exhibiting behaviours  
 17 which were challenging, that the smaller  
 18 staff-to-student ratios, even than our starting point,  
 19 was helpful.  
 20 We saw, when more children were back in school, what  
 21 I would refer to as an initial honeymoon phase where  
 22 children were relieved to be back, happy to re-establish  
 23 connections, and again, we saw reduced incidents of  
 24 distressed behaviours. But that changed once children  
 25 felt more settled and schools felt that they were seeing

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1 member schools and how that was impacted?  
 2 **A.** Again, I think the experience varied depending on  
 3 whether children were in school or out of school. Those  
 4 who were in school obviously continued to have learning  
 5 opportunities, but likely on a reduced curriculum and  
 6 with reduced demands. And then those who were not in  
 7 school may or may not have engaged with online learning,  
 8 likely would not have engaged with it.  
 9 I think schools found it very difficult to know  
 10 exactly what the lost learning was, that it was not easy  
 11 to say, "Well, you have missed X months and therefore if  
 12 you get those back in some form, you will be caught up."  
 13 Because it was so caught up in the learning  
 14 relationship, the behavioural overlays, it wasn't always  
 15 easy to say what was about missed learning and what was  
 16 about missed educational experience in a broader sense.  
 17 **Q.** Would I be right in saying that the learning that pupils  
 18 at your member schools do isn't tied to a specific  
 19 curriculum but tailored to them and their abilities and  
 20 the opportunities to help them thrive? Is that right?  
 21 **A.** I think broadly, yes. Schools would deliver national  
 22 curriculum subjects, but they would differentiate those  
 23 so that they would be applicable and meaningful for each  
 24 student. So you would see maths happening, you would  
 25 see science happening, but what it would look like for

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1 groups of children and individual children would be  
 2 different, dependent on their needs and where they are  
 3 at their learning stage.  
 4 **Q.** I see. And so, taking that one step further, if you're  
 5 considering the position of children at mainstream  
 6 schools, teachers would be able to say: well,  
 7 a 16-year-old at this term should be able to do these  
 8 things in the math curriculum by this stage, and we know  
 9 this because previous years have shown us that this is  
 10 what they should be able to do.

11 Is it not possible to do that kind of exercise with  
 12 learners at your member schools because of that  
 13 tailoring?

14 **A.** Yes, to a degree. Starting point and a real  
 15 understanding of need gives you some indication of what  
 16 you might expect a child to be achieving now and in  
 17 future terms. A lot of children make non-linear  
 18 progress and have, I guess, what we would call a spiky  
 19 profile, so you see peaks and troughs of learning,  
 20 learning that is generalised and transferred, and  
 21 learning that isn't. So it is more difficult, but it's  
 22 not impossible.

23 **Q.** Thank you. I'd just like to pick up on something you  
 24 mentioned about the children who remained at home and  
 25 whether they would be able to engage with online

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1 how that affected children at your member schools, and  
 2 indeed, the administration.

3 So, dealing firstly with the announcement of school  
 4 closures. The association, NASS if I can call it, was  
 5 in regular contact with the Department for Education  
 6 from around 9 March; is that right?

7 **A.** That's correct.

8 **Q.** Okay. And then on 16 March there were meetings with  
 9 officials which led you to believe that schools would  
 10 not be asked to close; is that right?

11 **A.** Yes.

12 **Q.** And when school closures were announced on 18 March, did  
 13 you know whether special schools were being asked to  
 14 close or not?

15 **A.** We had 45 minutes' notice of the announcement, at which  
 16 point it was uncertain what the position would be for  
 17 special schools.

18 **Q.** Okay. And obviously that uncertainty was resolved. Was  
 19 that about two days later? Am I right?

20 **A.** To a degree. I think it was unresolved exactly what was  
 21 being asked of schools. Because we were approaching the  
 22 Easter holidays, initially there were suggestions that  
 23 schools should stay open through Easter, and it took  
 24 several days before it was clear what was expected of  
 25 schools.

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1 learning. We've heard evidence in the Inquiry already  
 2 about the difficulty that some students with special  
 3 educational needs had with home learning and, in  
 4 particular, difficulties they had with having accessible  
 5 materials at home. And these are children in maintained  
 6 schools.

7 Was a similar difficulty with access to accessible  
 8 materials, was that encountered by your member schools?  
 9 Can you tell us?

10 **A.** It certainly was at the start of the pandemic, because  
 11 I think no school was well prepared to deliver remote  
 12 learning, and we didn't have easy access to remote  
 13 learning materials which were particularly adapted for  
 14 learners with special educational needs. For some  
 15 children, because of physical ability to use a keyboard  
 16 at home, it was always going to be a challenge to learn  
 17 remotely.

18 We heard of schools who had printed hard copy packs  
 19 and found those easier for some learners, but certainly  
 20 it was a challenge, particularly early in the pandemic.  
 21 We had schools that used the Oak Academy resources later  
 22 in the pandemic, but it did take a while for there to be  
 23 a number of these for special schools.

24 **Q.** Okay. I'm going to move on now to a different topic,  
 25 which is the government response to the pandemic, and

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1 **Q.** Okay. And what was the impact of that uncertainty on  
 2 your member schools?

3 **A.** I think in practice for children, I would hope  
 4 relatively little, but for the school leaders who were  
 5 trying to plan for that, huge stress about what they  
 6 were being asked to do, how they were being asked to do  
 7 it, what resources would be available to them, and  
 8 whether they would have the staff to be able to deliver  
 9 it. I think that was the key concern, because by this  
 10 point we were seeing schools staff who had Covid, who  
 11 were not going to be able to attend, and I think  
 12 initially there was the belief that it just might not be  
 13 possible to safely offer a service to enough children.

14 **Q.** Okay. And on 19 March, your schools were given  
 15 confirmation that they would be funded to remain open;  
 16 is that right?

17 **A.** Yes.

18 **Q.** That was a concern, was it, for member schools?

19 **A.** There were significant concerns for our independent  
 20 school members, who had been contacted in some cases by  
 21 placing local authorities to say that "If the go-ahead  
 22 is given for all schools to close, we will cease  
 23 payment."

24 **Q.** I see. So it was resolved on the 19th, so the day after  
 25 school closures was announced, that actually there would

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1 be funding to remain open?

2 **A.** Yeah.

3 **Q.** Okay. And then on 20 March, so two days later, it was  
4 confirmed that staff and special schools would be  
5 treated as key workers. I suppose that's also important  
6 if schools are to remain able to accept pupils?

7 **A.** Okay.

8 **Q.** What impression did you form about the Department for  
9 Education's preparedness for school closures?

10 **A.** I feel they were very underprepared. I think I've  
11 mentioned a number of times willingness of individual  
12 officials, but a real sense that the Department for  
13 Education was a secondary consideration within  
14 government as a whole, and felt that they were playing  
15 catch-up, which in turn meant that schools were playing  
16 catch-up, and we always felt that special schools were  
17 catching up several days, if at all, after guidance had  
18 been issued to mainstream schools.

19 It felt that there had not been a solid plan in  
20 advance, and it felt as if that plan was being formed  
21 and reformed on the spot, really.

22 **Q.** We heard this morning in evidence that children were the  
23 second tier of priorities for us as a nation. Would you  
24 agree with that sentiment?

25 **A.** Absolutely. We were given lots of information that the  
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1 support is particularly needed for clinically vulnerable  
2 children and those in clinically vulnerable families, or  
3 following on from what you've just said, is your  
4 position that that would be important for all children  
5 in families?

6 **A.** I would make a particular case for children with special  
7 educational needs because they are at a higher risk of  
8 developing a mental health problem, and yet they are  
9 often excluded from mainstream mental health services.

10 So children with learning disabilities may not be  
11 offered talking therapies. A lot of psychological  
12 therapies are not aimed at children with special  
13 educational needs and/or autism, and I think they are  
14 a largely neglected group.

15 **Q.** Okay. And my final question for you is, taking a step  
16 back and overall examining the government's response to  
17 the pandemic and how children at member schools were  
18 affected, what recommendations would you have for any  
19 future pandemic?

20 **A.** I think it is essential to recognise the impact on  
21 children and to factor that in from planning at the  
22 earliest stage. I think the Department for Education  
23 needed to be a far more central department within  
24 government within the pandemic planning. And I would  
25 like more awareness of what the real losses are to  
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1 virus wouldn't affect children in the same way, that  
2 children wouldn't get Long Covid, that children would  
3 bounce back without serious problems. I didn't ever see  
4 a persuasive evidence base for that being the case, and  
5 I think experience has told us since that it wasn't the  
6 case.

7 **Q.** Okay. Just before I conclude by asking you about your  
8 recommendations, I'd like to ask you about a statement  
9 in your witness statement, you say that many schools  
10 were taking a "trauma informed" approach to mental  
11 health provision for children because many children's  
12 experience of the pandemic will have been traumatic.

13 Do you think that this applies particularly to  
14 clinically vulnerable children and children who live in  
15 families with a clinically vulnerable member? Or does  
16 it apply equally to all children who experience  
17 bereavements and reduced connections during the  
18 pandemic?

19 **A.** I would say for all children. I think if you look at  
20 the numbers of life traumas children experience,  
21 children with special educational needs often have  
22 experienced a larger number of adverse childhood  
23 experiences but I believe this is relevant for all  
24 children.

25 **Q.** Okay. And do you think that targeted mental health  
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1 children during a pandemic. And of course, for schools,  
2 lost learning is really important, but the loss of  
3 relationship in learning, the loss of the wider  
4 experience of education, and the impact that had on  
5 mental health and wellbeing I think is causing more  
6 problems now than whether or not certain elements of the  
7 curriculum were not covered.

8 **MS POTTLE:** Thank you very much, Ms Dorer. I don't have any  
9 further questions for you.

10 My Lady, there are no questions from Core  
11 Participants for Ms Dorer. Do you have any questions  
12 for the witness?

13 **LADY HALLETT:** No, I don't. Thank you very much indeed,  
14 Ms Pottle.

15 Ms Dorer, thank you very much for the help you've  
16 given to the Inquiry and for coming along today to  
17 assist us again. I'm really grateful.

18 **THE WITNESS:** You're welcome.

19 **MS POTTLE:** Yes.

20 My Lady, next this afternoon, before the break, we  
21 have another witness, and that's Ms Alison Morton.  
22 She's just being brought into the witness box now.

23 **MS ALISON MORTON (sworn)**

24 **Questions from COUNSEL TO THE INQUIRY**

25 **LADY HALLETT:** Ms Morton, I hope we haven't kept you waiting  
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1 too long.

2 **THE WITNESS:** No, not at all. Thank you.

3 **MS POTTLE:** Ms Morton, can you please give us your full  
4 name.

5 **A.** Alison Jane Morton.

6 **Q.** Thank you for attending and for providing a helpful  
7 witness statement to this Inquiry. It is -- it should  
8 be in front of you and the reference is INQ000587870?

9 **A.** That's correct.

10 **Q.** Ms Morton, you are the CEO of the Institute of Health  
11 Visiting; is that right?

12 **A.** That's correct.

13 **Q.** What is the mission and purpose of the Institute of  
14 Health Visiting?

15 **A.** So, we are a fairly new professional body, we were  
16 established in 2012 to really lead excellence in health  
17 visiting -- in England primarily, at the start; we're  
18 now UK wide. We have four areas of our work --

19 **Q.** Sorry, if we could just pause you there. We just need  
20 to go a bit more slowly. The stenographer is making  
21 a note, a transcript of your evidence.

22 **A.** Okay, fair enough.

23 **Q.** So you said primarily established in England, in --

24 **A.** In 2012, that's correct.

25 **Q.** In 2012.

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1 epigenetic changes in the brains of babies. So it's  
2 really crucial.

3 In terms of health visitors, so we are specialist  
4 community public health nurses, so a background in  
5 nursing or midwifery. We then work with all families.  
6 So what's unique about health visitors, we've had  
7 specialist training to work with families across  
8 physical health and mental health -- and that's for  
9 children and their parents -- child development, social  
10 needs and safeguarding.

11 And probably to summarise, the unique contributions  
12 of health visiting, as part of the health workforce, is  
13 our reach, our range of skills and our response.

14 So we are only the service that proactively and  
15 systematically reaches all families with babies and  
16 young children from pregnancy to the age of 5, and that  
17 has unique contribution across the health education and  
18 social care system.

19 And in terms of our range of skills, so we're able  
20 to work with an undifferentiated population. So we're  
21 going into families' homes and can give parents health  
22 promotion advice to give their child the very best start  
23 but we're also looking for deviations from the norm, you  
24 could put it, for children who aren't thriving and for  
25 parents who need a little bit of extra support because

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1 **A.** And there are four areas of our work: learning and  
2 development, so that's about health visitor training;  
3 innovation and reach; we do some work to influence  
4 policy; and then we support a membership.

5 **Q.** Okay. And the Institute of Health Visiting is  
6 registered as a charity in England and Wales; is that  
7 right?

8 **A.** That's correct.

9 **Q.** But I think you told us it has growing membership in  
10 Scotland and Northern Ireland --

11 **A.** That's correct.

12 **Q.** -- is that right? Okay.

13 Can I begin by asking you, what is the significance  
14 of the first years of a child's life from a health  
15 visiting perspective, and how do health visiting  
16 services contribute to the best start in life for  
17 children?

18 **A.** Okay, so there's global evidence that tell us that the  
19 first 1001 days is the most critical period of human  
20 development. It's a time when babies' brains can be  
21 shaped by the environment in which they live, either  
22 positively or negatively. So if you're in a nurturing  
23 environment, children do well. If you're in an  
24 environment where you're exposed to increased stress, it  
25 can impact brain development and actually cause

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1 we know that small problems can grow into big problems  
2 if we leave them, and that's across the whole remit of  
3 skills that I mentioned earlier.

4 And then in terms of our response, health visitors  
5 offer three levels of support: so the universal offer  
6 that I've mentioned. We also offer targeted and  
7 specialist support to families with increased need, and  
8 either deliver that directly or we connect families to  
9 the wider support system, so that might be specialist  
10 services or voluntary sector groups that might benefit  
11 families in those early years which are -- can be highly  
12 stressful for any family, having a new baby.

13 **Q.** Of course. You talked about the sort of universal  
14 offer, and -- so that's the five mandated contacts; is  
15 that right?

16 **A.** That's correct.

17 **Q.** And those are contacts that are made with every family,  
18 so there's the antenatal contact and then the contact  
19 shortly after the child is born; is that right?

20 **A.** That's right.

21 **Q.** And then following on from that, when is the next  
22 contact?

23 **A.** So the first three contacts -- so the first two you've  
24 just described, and then the third one is the six week  
25 contact, and all of those three really form the first

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1 assessment, because it's such a dynamic period of  
2 change. How you are in pregnancy can change after birth  
3 and by the time you get to six weeks you can have  
4 a reasonably good idea about how a family are doing. So  
5 those three clustered together. And then there are two  
6 further checks: one at 1 year and the other one between  
7 2 to 2½.

8 **Q.** I see. And you said that health visitors can also offer  
9 additional support if that's required, and so please  
10 correct me if I'm wrong, a health visitor would see  
11 a family during those required visits and if they picked  
12 up on, let's say, a poor perinatal mental health, then  
13 they could offer additional contacts or referral to  
14 other services; is that right?

15 **A.** That's correct. So the example that you've just used,  
16 for perinatal mental health, that can range from  
17 a mother who might be struggling with depression, which  
18 could be managed by a health visitor in the community or  
19 it might be a mother who's on the verge of suicide and  
20 we'd be looking for red flags for suicide, or a parent  
21 who had very serious mental illness that would need to  
22 be supported by specialist services.

23 So the health visitor has a crucial role connecting  
24 those families to the best support available.

25 For other families it might be loneliness and they  
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1 this is really important because often need is hidden.  
2 But if we have a relationship with the families, then  
3 often they will start to tell us about the things that  
4 are really bothering them, and that might be domestic  
5 abuse, serious mental illness, intrusive thoughts, lots  
6 of things which can impact on parenting.

7 **Q.** And is seeing the family -- I think you touched on this  
8 briefly -- in the home environment, why is it  
9 particularly important or significant that health  
10 visitors see babies and families in their own  
11 environment?

12 **A.** Yes, really significant. So you are seeing the child in  
13 the context in which they live. As soon as you walk  
14 into that home, you're, without even consciously  
15 thinking about it -- when you ask health visitors what  
16 they're doing, you're scanning the environment and  
17 you're looking for signs of anything that's not quite  
18 right in that home, I guess. Substance misuse, the  
19 smell of neglect and poverty. There is a smell, when  
20 you walk into a family's home, which you can spot. The  
21 interaction between the child and its parents can tell  
22 you an awful lot about child maltreatment, how the child  
23 is dressed -- you know, we're not looking to see whether  
24 the houses are tidy. You know, it's something very  
25 different that we're looking for. Looking for signs of

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1 need to go to parent and toddler group, for example, or  
2 one of the wonderful services offered by many charities.

3 **Q.** Okay, and just before we move on from that, I'd like to  
4 ask you in particular about safeguarding. That is  
5 a topic of particular interest in this module. What  
6 role do health visitors play in safeguarding children?

7 **A.** So, fundamentally, need is often hidden in family homes,  
8 and so this is why the reach is so important, to get out  
9 into family's home and to see the baby in the context of  
10 the family in which it's living in.

11 And our radar is up, our primary role is as  
12 a specialist nurse to improve public health, but  
13 safeguarding is a thread that runs through everything.  
14 Safeguarding incidents don't just happen out of the  
15 blue. Normally, families will gradually deteriorate and  
16 life will become more difficult for them, and the idea  
17 is we spot families early, before it reaches crisis  
18 point, and support them to get early intervention that  
19 can make a difference.

20 But equally, we'll be out there looking for the  
21 signs of abuse, child abuse, which could be physical  
22 abuse, sexual abuse, emotional abuse, neglect, and we'll  
23 be looking for those signs when we're working with  
24 families. We're fundamentally trying to build that  
25 relationship with families so that we elicit need. And

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1 neglect.

2 And I can tell you hundreds of times where I've  
3 walked into a family's home where you might see them on  
4 the high street or they come to the clinic and  
5 everything looks fine and then when you go in the  
6 home -- yeah, I remember a mother that I went to see  
7 where literally it was knee-high nappies around her  
8 living room. She was shut behind curtains, kind of  
9 rocking on her bed, because she couldn't cope with her  
10 baby and she didn't know what to do. And because I was  
11 the health visitor, I could get in there and say -- and  
12 the interesting thing was, I knew this mother when she  
13 was pregnant, and she'd been brought up in care, and she  
14 told me that she wanted to be a great parent, and  
15 I believed her.

16 And so when I went into the home and I saw the  
17 nappies and every dirty plate you could imagine, I said  
18 to her, "How can we get you back to where you were, what  
19 you wanted to be?" And that's the role. It makes me  
20 emotional talking about it.

21 **Q.** Of course.

22 **A.** And that's the role of the health visitor, to get  
23 alongside families.

24 **Q.** Okay. I want to move on to ask you a bit about the  
25 pandemic response to health visiting in England, but

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1 just before I do that, can I just cover with you, very  
2 briefly, health visitors, the workforce. In March 2020,  
3 how did the workforce numbers compare in March 2020 with  
4 previous years?

5 **A.** Okay. So health visitors has been on a rollercoaster  
6 over generations. It feels like society remembers and  
7 then forgets how useful we are. And so prior to  
8 David Cameron's government they had come to an all-time  
9 low, and so he put in what was called the Health Visitor  
10 Implementation Plan, and increased the number of health  
11 visitors to just above 11,000 in England. It was a big  
12 piece of work that spanned four years.

13 And since 2015, when that peaked, we've seen a --  
14 well, now, where we are today, a 42% reduction in the  
15 number of health visitors. But at the start of the  
16 pandemic it was 30% under the 2015 high. And so it slid  
17 down, and it's carried on sliding. There are no brakes  
18 on this.

19 **Q.** Okay. And I suppose it follows on from that that the  
20 caseloads for each health visitor, because the number of  
21 children isn't decreasing by 30%, so the caseloads for  
22 health visitors were higher than --

23 **A.** Yes.

24 **Q.** -- in March 2020 than they had been back in 2015; is  
25 that right?

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1 reasons: to free up the maximum possible inpatient and  
2 critical care capacity.

3 And then if we can go on to page 5, please,  
4 paragraph 3(g). So the directive was:

5 "All appropriate registered Nurses, Midwives and  
6 AHPs ..."

7 That's allied health professionals, that would  
8 include health visitors; is that right?

9 **A.** That's correct.

10 **Q.** Yes.

11 "... currently in non-patient facing roles will be  
12 asked to support direct clinical practice in the NHS in  
13 the next few weeks ..."

14 We can take that down.

15 So am I right in thinking that this was the basis  
16 for the redeployment of health visitors? Not every  
17 health visitor but many health visitors; is that right?

18 **A.** Yes, that's correct.

19 **Q.** And in your view, was it appropriate to classify health  
20 visitors as being in non-patient-facing roles?

21 **A.** Not health visitors in general. So the term was  
22 interpreted in very different ways. So the range of  
23 redeployment ranged from zero to 63%, so in about  
24 a third of provider trusts no health visitors were  
25 redeployed but in the rest they were and it was down to

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1 **A.** That's correct, yes.

2 **Q.** Okay.

3 **A.** So Gabriella Conti did some research in February 2020,  
4 and she reported that the health visitor caseload sizes,  
5 80% of health visitors had caseloads of more than 250,  
6 which was the recommendation modelled by David Cameron's  
7 government.

8 **Q.** Okay, so 80% had caseloads in excess of 250, which was  
9 the recommended number?

10 **A.** Yes.

11 **Q.** Okay. Now I'm going to move on to the pandemic response  
12 and how that impacted on health visiting.

13 First, I'd like to ask you about redeployment and  
14 the partial stop to the service, and my Lady has heard  
15 a lot already about the phase I letter, so I'll try to  
16 take this briefly.

17 On 17 March of 2020 the NHS chief executive wrote to  
18 all NHS trusts and providers of community health  
19 services outlining actions that he was asking every part  
20 of the NHS to put in place to protect the NHS, and the  
21 letter included a direction to redeploy health visitors  
22 to direct clinical practice.

23 And if I could just pull that letter up now, it's  
24 INQ000087317.

25 And here this is page 1, and we can see the

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1 local modelling and that interpretation of that term,  
2 and so in principle, what they were asked to do was make  
3 sure there was enough capacity to deliver the core  
4 service that -- most of the service had been stopped,  
5 but also to respond to need.

6 And so our view is it was inappropriate to redeploy  
7 health visitors because they were needed most on their  
8 own front line. We strongly predicted that need would  
9 go up, and it was totally inappropriate.

10 **Q.** Okay. And you say 63% of health visitors you think were  
11 redeployed. In your witness statement you say that  
12 there's not a dataset that captures this information, so  
13 how was that figure arrived at?

14 **A.** So this was a really comprehensive piece of research led  
15 by Professor Gabriella Conti which I thank her for doing  
16 it, based on Freedom of Information, and she asked all  
17 local authority providers to send information on the  
18 level of redeployment.

19 And just to confirm that it was up to 63% within  
20 provider trusts, so that was the peak, so there was a  
21 large range.

22 **Q.** Yes.

23 **A.** So it wasn't 63% of health visitors, but it raises an  
24 issue that we still don't know how many were redeployed.

25 Because there was no national dataset to collect that

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1 information. What we do know is in the areas where they  
2 were redeployed it has a massive impact on the health  
3 visitors who were remaining.

4 **Q.** Yes, well, in fact, I'd like to now take you to  
5 Professor Conti's report, which is -- ah, thank you very  
6 much. This is a publication about the impact of  
7 Covid-19 on health visiting in England, authored by  
8 Professor Conti and Abigail Dow.

9 Can we move to page 4, please.

10 So in this article, Professor Conti draws out the  
11 impact of redeployment on health visiting caseloads. So  
12 if we look at the text there:

13 "Health visitors who were not redeployed were faced  
14 with increased caseloads during a time of great  
15 uncertainty ... 38% of respondents reported an increase  
16 in the caseload size -- the number of children they were  
17 responsible for ... three-quarters ... were already  
18 caseload holders," and one in five acquired a caseload  
19 after 19 March.

20 And then the distribution of increases in caseload  
21 size are displayed in the figure which we'll turn to in  
22 a moment, but it is summarised here: a number of  
23 respondents had their caseload increased by up to 200  
24 children.

25 Just pausing there, you had said, I think, in your  
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1 families down. It means less time for families.

2 **Q.** Okay. Well, I'd like to take you now to a document.  
3 INQ000587957, please.

4 This is an excerpt from the expert report which,  
5 my Lady, we've covered briefly -- pardon me, we've  
6 covered already, Professor Catherine Davies, the child  
7 development expert. In her report she notes that:

8 "Health visitors, particularly in England, reported  
9 feeling overwhelmed and underprepared to meet the  
10 growing needs of families. In 2021, only 9% of health  
11 visitors in England reported working within the  
12 recommended caseload of 250 children, per full-time  
13 equivalent ... compared to around two-thirds in Scotland  
14 and Wales. In England, 49% reporting caseloads of  
15 500-699 children; in Scotland the corresponding figure  
16 was just 3%.

17 "More than one in four health visitors in England  
18 were responsible for over 750 children, whereas no  
19 health visitors in Scotland or Wales reported such high  
20 caseloads."

21 And so I take it, Ms Morton, from your evidence --  
22 that can come down now -- from your evidence comparing  
23 health visitors to midwives, who have a caseload of 35,  
24 that those caseloads, those very high caseloads, you  
25 think, and correct me if I'm wrong, that that would have  
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1 evidence that the recommended number overall is 250  
2 children; is that right?

3 **A.** Yes, so that's 200 more than the original caseload that  
4 they have. We don't have a benchmark of what it was in  
5 that research, but yes, 200 extra children. And to put  
6 that into context so --

7 **Q.** Just before we do that, can we look at the figure now,  
8 please -- yes, table 2, pardon me.

9 So we can see here the increase in caseload size.  
10 So among the respondents, the highest percentage had  
11 a relatively modest increase of one to ten children, but  
12 some 20% of respondents, at the bottom of the table  
13 here, we can see had either between 51 and 100 more  
14 children, or between 101 and 200 more children on to  
15 their original caseload.

16 Okay, we can take that down.

17 **A.** Thank you.

18 **Q.** Sorry, you were saying, just to put that figure into  
19 context?

20 **A.** What I was going to say is that a midwife has a caseload  
21 of about 35 families and a social worker about 25. And  
22 the worst we heard when we were surveying this is that  
23 some health visitors had caseloads of 750 children,  
24 which is literally impossible. Nobody can manage that  
25 many children. It's just a paper exercise and we let  
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1 interfered with the ability of a health visitor to  
2 deliver the service required; is that right?

3 **A.** A hundred per cent, yes. So what happened is they had  
4 to prioritise, and prioritisation has a human cost so  
5 that means some people had to be told, "Sorry, I can't  
6 help you." And health visitors had to deliver that  
7 message. They were the front line, I guess taking the  
8 flak for having insufficient capacity to meet families'  
9 needs in the way they wanted to. Health visitors want  
10 to come to work to support families and deliver  
11 high-quality care.

12 **Q.** Okay. I'm now going to move on to another topic which  
13 is the partial stop of the service.

14 On 20 March, NHS England and NHS Improvement  
15 published the first iteration of the Covid-19  
16 Prioritisation Within Community Health Services Plan,  
17 and if we can take that up now. We've actually seen it  
18 this morning very briefly.

19 The reference is INQ000059706.

20 So this is the letter -- just sticking with page 1  
21 for a moment, it sets out, at point 2, that:

22 "By default, practitioners are to use digital  
23 technology to provide advice and to support patients  
24 wherever possible."

25 And then if we scroll down, please, through to  
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1 page 3, so this was the letter about community  
2 healthcare and how it would be impacted. And yes, we  
3 saw this, this morning.

4 So there is a schedule, if you like, for children  
5 and young people's services, some would stop fully, and  
6 then the partial stopped services included vision  
7 screening, and if we continue on, yes, here we are.  
8 Number 5. This is a service that was to be partially  
9 stop, so pre-birth and 0-5 service, which is health  
10 visiting. And the direction was to:

11 "Stop except:

12 "Stratify visits and support for vulnerable families

13 "Safeguarding work

14 "All new-birth visits

15 "Follow-up of high risk mothers, babies and families

16 "Antenatal visits and support (but consider virtual)

17 "Phone and text advice -- digital signposting."

18 And blood spot screening was to continue.

19 We can take that down.

20 Am I right in thinking that, as a result of this  
21 directive, that families then would not be offered the  
22 five mandated universal health contacts, but that  
23 instead they would have -- and this for all families,  
24 I appreciate the position is somewhat different for  
25 vulnerable families, but for all families, they would  
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1 at the beginning of your evidence about health visitors  
2 going into the home and spotting need. With this  
3 partial stop, is it the case that some children who  
4 might not have been identified as being vulnerable, or  
5 families who weren't identified as being vulnerable,  
6 would not have been seen and would not have been  
7 spotted? Is that right?

8 **A.** That was our biggest worry, because we felt that the  
9 logic was flawed to focus on known vulnerable, because  
10 the whole point of the health visiting service is to  
11 spot the children who are vulnerable. And this period  
12 between pregnancy and the age of 1 is a very high risk  
13 period for babies -- and for women, actually. So you  
14 have the highest rate of homicide, the highest rate of  
15 serious incidents. The highest rate of women taking  
16 their life through suicide is in the period,  
17 interestingly, from 6 weeks up to 12 months, and that is  
18 long after the midwifery services have gone.

19 And so, in essence, we were stripping away this key  
20 health service to reach into families' homes in a very  
21 vulnerable time.

22 And what we know is some families will ask for help,  
23 but some can't, and some won't. Can't because they  
24 haven't got capacity or they feel overwhelmed, maybe  
25 they feel stigma. And won't, because there are some  
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1 just have the antenatal contact and the new baby visit;  
2 is that right?

3 **A.** That's correct.

4 **Q.** Okay. And in respect of vulnerable families, was there  
5 additional guidance to help health visitors determine  
6 which cases to prioritise and who should be classed as  
7 vulnerable?

8 **A.** So, no, there wasn't any national guidance at the time,  
9 in terms of what constituted vulnerability. There were  
10 three high levels of vulnerability that were set out:  
11 children who were clinically vulnerable; children who  
12 were under the care of children's social care,  
13 looked-after children in child protection, child in need  
14 families; and then there was this generic level of  
15 children with additional vulnerabilities for  
16 environmental factors and other factors.

17 But there was no national definition for that at the  
18 start of the pandemic. That didn't come until about  
19 September 2020. So that had massive implications in  
20 terms of -- well, first of all, clinically, knowing who  
21 to triage and to prioritise, and, secondly, for service  
22 level planning, in terms of making sure you had  
23 sufficient capacity to meet those needs.

24 **Q.** Okay.

25 Something else I want to ask you about is you spoke  
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1 families, small numbers, who want to cause harm to their  
2 children. And so that made children vulnerable.

3 And the other thing to say, this is a dynamic period  
4 of change. So you might be perfectly fine at the  
5 new birth visit and things will come crashing down a few  
6 weeks later. And the whole purpose of that six-week  
7 contact is to find particularly perinatal mental health  
8 problems, which go up, often not manifested at the new  
9 birth visit. So cutting that six-week contact was  
10 a crucial one to cut for us.

11 But also losing the eyes on those infants who are  
12 citizens in their own right and don't have a voice. Who  
13 was going to spot babies in distress in their home? And  
14 that was a key role for the health visitor which was  
15 stripped out and wasn't really appreciated, I don't  
16 think, or the significance -- the protection wasn't  
17 afforded to them.

18 And one of the things I always mention is that  
19 school-age children get seen 38 weeks of the year,  
20 five days a week, by an adult outside of the home. If  
21 you look at the rates of referrals to children's social  
22 care, and I included it in one of my evidence  
23 submissions, exhibits, you'll see that they fall during  
24 the school holidays, and increase when children go back  
25 to school.  
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1 So that tells us something very significant about  
2 the role of adults outside the family home in spotting  
3 vulnerability, and babies aren't afforded that  
4 protection. The only service they have is health  
5 visitors that reaches all families, and that was  
6 stripped out. And that had a huge cost, and some  
7 children paid the highest price.

8 **Q.** Before we move on to discuss the impact on children and  
9 the families themselves, I'd just like to ask you a bit  
10 more about the use of digital technology.

11 So we saw in that prioritisation plan a requirement  
12 that digital technology be used wherever possible, and  
13 I think you've already told us in your evidence about  
14 the importance of the home visit, of the visits taking  
15 place in a child's home.

16 In your view, was digital technology able to provide  
17 a reasonable level of service for home visiting? Was it  
18 a service that could safely be delivered remotely?

19 **A.** So I think digital had some benefits, health visitors  
20 had some experience of using digital prior to the  
21 pandemic. They were, in terms of nursing, on the front  
22 foot. So we had things like ChatHealth, a text  
23 messaging service that parents could text us and get  
24 real-time advice. We used the website quite a lot.

25 But in terms of replacing -- there's two issues.  
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1 what we did at the Institute of Health Visiting is we  
2 looked across the country -- I'd actually worked  
3 previously with a professor, Carl May, who did research  
4 into telemedicine, so knew where to look for how do we  
5 implement this as best as we can. It was never meant to  
6 replace those contacts. It was suboptimal, it was  
7 a 'better than nothing' alternative, but it wasn't  
8 a health review.

9 So we wrote some advice, practical advice, for  
10 health visitors how to implement, but they lacked the --  
11 many areas lack -- lacked the IT equipment to do that  
12 quickly. So it was a huge learning curve for services  
13 to quickly find the kit that they needed.

14 **Q.** Okay.

15 **A.** But quickly they did, yeah.

16 **Q.** Okay. So at the very beginning there wasn't  
17 necessarily -- there wasn't the equipment or advice in  
18 place, but as things progressed, advice was put in  
19 place --

20 **A.** Yes.

21 **Q.** -- and the equipment was found. I just want to pick up  
22 on one aspect of your response, and you said it was  
23 never meant to be more than a temporary thing. I take  
24 it from that that some remote health visiting service  
25 continues; is that right?  
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1 Replacing a quick contact to give advice, perfectly  
2 fine. Replacing a mandated universal holistic  
3 assessment, impossible. You can't deliver what you're  
4 supposed to deliver over the telephone. You can't  
5 assess a baby if you can't see it. And when you look at  
6 the schedule of interventions for the Healthy Child  
7 Programme, it sets out a whole raft of tasks that the  
8 health visitor is supposed to complete:

9 Assessing child growth. Well, you can't weigh them  
10 over the phone, adjusted simplistic.

11 Looking at parent-infant interaction. You can't see  
12 that over the phone.

13 Looking at the wider context of the family home, the  
14 safeguarding elements that I've mentioned. You can't do  
15 that over the phone.

16 So there were loads of things that were missing.  
17 Infant mental health is a new area that we're working in  
18 in health visiting, so looking at the way the baby  
19 interacts with the parent. And you can't see that over  
20 the telephone.

21 **Q.** And were training and equipment made available to health  
22 visitors to carry out their roles virtually, do you  
23 know?

24 **A.** So, at the start of the pandemic, this was the brave new  
25 world, so we hadn't done video contacts at all, and so  
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1 **A.** Yes, absolutely. Yes, yes. So -- and our view is it's  
2 perfectly fine for follow-on contacts, but not for the  
3 universal assessment. And that really is a sharp line  
4 for us. We don't think you can replace it.

5 And what the problem was, was those virtual contacts  
6 got counted in the national dataset, which massively  
7 skews the England data. So it looks like children are  
8 being -- having this holistic assessment, when in actual  
9 fact some might have had a one-hour home visit, with  
10 PPE, and the others -- I mean, I heard stories of  
11 45-second phone calls to families.

12 So you have to put this into context. And I'm not  
13 wanting to judge the health visitors out there, I'm on  
14 their side. They did their very best. But if you have  
15 huge numbers of children that you're just trying to get  
16 a sense of who's vulnerable, often they're -- you know,  
17 administrators were ringing families up and saying, you  
18 know, "We're just working out who needs a contact. Are  
19 you okay?"

20 "Yes, I'm fine."

21 And then ticking that as you've had the contact.  
22 And it can't possibly be the same.

23 **Q.** Okay. And so I take it from your answer that when it  
24 comes to data recording whether universal contacts have  
25 taken place, there isn't a distinction in the data  
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1 between virtual contacts and those that are in person;  
 2 is that right?  
 3 **A.** No. Not with the main data collection method. There is  
 4 a voluntary dataset which has been brought in, which is  
 5 starting to collect that, but not routinely for all  
 6 provider trusts, no.  
 7 **Q.** Okay. Can you help us with when the redeployment came  
 8 to an end? So I think in your witness statement you  
 9 deal with this at paragraphs 39 to 40.1.  
 10 **A.** So that was an interesting one. So it went on for quite  
 11 a long time. We know that the average duration of  
 12 redeployment was about 2.2 months but there was a huge  
 13 range. So some areas brought their health visitors back  
 14 very quickly, and others -- at the summer of 2020 we had  
 15 regular contacts with the government saying we were  
 16 concerned that health visitors were still being  
 17 redeployed, and it took until 2 October, when a letter  
 18 was finally pushed through, led by Ruth May, the Chief  
 19 Nursing Officer for England -- and I thank her for her  
 20 intervention for that -- sending a letter out to trusts  
 21 to say health visiting redeployment must end.  
 22 And that was -- I guess that was the final point  
 23 where we really started to see it shift and health  
 24 visitors were brought back. So a lengthy process of  
 25 redeployment. But again, as we approached December, and  
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1 to answer telephones, to deliver parcels of  
 2 prescriptions, and that, you know, really saddened  
 3 health visitors to know that their families were left  
 4 behind in huge need, because needs soared through the  
 5 roof, and health visitors were out there doing jobs that  
 6 could have been managed by somebody else. It didn't  
 7 need to have this tiny 6,000 health visitor workforce  
 8 redeployed when they were needed most with families.  
 9 **LADY HALLETT:** Thank you.  
 10 **MS POTTLE:** I'm going to ask you now about an evaluation of  
 11 the impact of the changes to health visiting on children  
 12 and their families. I think you've given evidence about  
 13 the role that health visitors play in safeguarding. In  
 14 your statement, you report a figure that 82% of health  
 15 visitors who were surveyed reported an increase in  
 16 domestic abuse in 2020. Is that right?  
 17 **A.** That's correct, yes.  
 18 **Q.** And that -- you also deal with the thematic analysis  
 19 commissioned by the Child Safeguarding Review Practice  
 20 Panel which was published in 2021, which identified  
 21 a key factor which increased the risk to children, was  
 22 the impact of adaptations for Covid safe practice.  
 23 So if I can -- I'll just pull it up now, Ms Morton.  
 24 It's INQ000103841, and this is the graph from the Child  
 25 Safeguarding Review Practice Panel and it says:  
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1 there was talk of this -- kind of, the winter surge  
 2 coming, and then the vaccinations were coming on board,  
 3 there were also suggestions that health visitors should  
 4 be redeployed again in December, and we really had to  
 5 make a strong intervention for that not to be the case.  
 6 And it was stopped, thank goodness.  
 7 **Q.** Yes, so there wasn't a second redeployment of health  
 8 visitors?  
 9 **A.** No, no.  
 10 **Q.** That's right. Okay.  
 11 **A.** But I think a lot of people wanted them to be redeployed  
 12 because they were incredibly helpful in their redeployed  
 13 roles.  
 14 **LADY HALLETT:** What were those roles? Sorry to interrupt.  
 15 What were those roles, Ms Morton, roughly? I mean,  
 16 I appreciate it's hard to generalise but ...  
 17 **A.** Yes. I think the intention was that they were qualified  
 18 nurses so they would go and work in NHS hospitals to  
 19 support acute health care and that's what the minister  
 20 Jo Churchill said, health visitors were most needed to  
 21 care for acutely ill patients. We would disagree with  
 22 that. We think they were most needed to care for  
 23 families.  
 24 So some went off to hospitals to do nursing, but the  
 25 worst thing was some were sent off to do administration,  
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1 "The relative impact of Covid-19 factors in a sample  
 2 of cases audited by the panel", and the adaptations for  
 3 Covid-safe delivery -- it should be just on the screen  
 4 in front of you.  
 5 **A.** Yes.  
 6 **Q.** Yes. We can see there a significant impact in 16 cases,  
 7 and some impact in two. And I suppose adaptations for  
 8 safe delivery would include virtual visits from home  
 9 visitors; is that right?  
 10 **A.** Yes, that's right.  
 11 **Q.** Okay. And so I think in your evidence earlier this  
 12 afternoon you said that you thought that because of  
 13 a lack of home visits by health visitors, some children  
 14 paid a high price. Would you agree that the results of  
 15 the Child Safeguarding Review Practice Panel bear out  
 16 the impact of virtual working by home visitors on some  
 17 of the cases that they had looked at?  
 18 **A.** Yes. For me, this was a serious wake-up call, because  
 19 this was hard, concrete evidence that children were  
 20 being harmed by these practices. So there were two  
 21 categories of impact. So one was that the adaptations  
 22 for Covid-safe and the other was the increase in family  
 23 and parental stresses and both are significant in the  
 24 deaths, or in serious incidences for these children,  
 25 which had catastrophic life-ending and life-changing  
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1 consequences for these children.

2 And they were the canary in the coalmine and we  
3 needed to listen to them and make their voices count,  
4 even in their deaths. Children like Star Hobson and  
5 Arthur Labinjo-Hughes hit the headlines, and there were  
6 many others. And I guess, for me, this is the most sad  
7 part of the pandemic, how we let these children down.

8 **Q.** Okay. We can take that down now. Thank you.

9 In terms of perinatal mental health, how did the  
10 pandemic impact on perinatal mental illness, and you  
11 deal with this in your witness statements at  
12 paragraphs 118 and 119.

13 **A.** Okay. So the pandemic exacerbated family stresses.  
14 I mean, that was plain to see, and had a significant  
15 impact on perinatal mental illness. In one study very  
16 early in the pandemic, 50% of mothers surveyed in London  
17 reached the category -- the threshold for post-natal  
18 depression and health visitors were concerned for two  
19 reasons. So one was this increase in risk factors, and  
20 things like social isolation, lack of support, just  
21 imagine what it feels like to leave hospital with your  
22 new baby, and you can't see your family, you don't have  
23 any help from the health visitor, and you have not done  
24 this before, you know. So it was entirely predicted  
25 that this was going to happen.

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1 that -- well, firstly, they had more comprehensive  
2 services before they went into the pandemic. So they  
3 were better staffed at the start. So we were on the  
4 back foot in England, but in the other nations, they  
5 were better equipped.

6 Redeployment, as far as I know, was much more  
7 measured. Less were sent and they were returned  
8 quicker. Face-to-face and non-face-to-face, they had  
9 the same issues that we had in England, but the sense  
10 that I've heard is that they had quicker access to PPE,  
11 and that was the rate-limiting factor for doing home  
12 visits, not having PPE, and then fundamentally, their  
13 services were reinstated faster, and the good news is  
14 that the governments in the devolved nations have all  
15 committed to further investing in health visiting.

16 **Q.** Okay. I'm going to move on now to your reflections and  
17 recommendations for the future. And just taking a step  
18 back from the detail of the evidence that you've given  
19 us, can I ask you, overall, in view of the Institute of  
20 Health Visiting, was redeployment and a partial stop to  
21 the service a proportionate measure to protect the NHS  
22 during the first wave of the pandemic?

23 **A.** I don't think it was appropriate. I think, knowing,  
24 with the global evidence that we had, so the harms of  
25 doing that were entirely foreseeable and predictable and

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1 But then the second concern was the lack of capacity  
2 to find these women and to get alongside them and to  
3 offer help, because we know that early intervention  
4 makes a huge difference to outcomes.

5 **Q.** Okay, and sticking with perinatal mental health, why is  
6 it important that issues with perinatal mental illness  
7 are picked up for babies in particular?

8 **A.** Okay. So for babies, whilst not inevitable, having  
9 a mental illness can impact parenting capacity. There  
10 are many parents out there with mental illness who do  
11 a great job, but the risk of not doing well is higher if  
12 you have a mental illness. It's harder to tune into  
13 your baby. You neglect yourself, you neglect your baby,  
14 and at the psychotic end, you know, it can have  
15 catastrophic harms, both for women and for the infants  
16 themselves.

17 **Q.** Okay. I'm going to ask you now, just briefly, about the  
18 devolved administrations. So we know that the Institute  
19 of Health Visiting is registered in England and Wales,  
20 but I'd like to ask you just briefly if you can help us  
21 with whether redeployment took place in Scotland, Wales  
22 and Northern Ireland.

23 **A.** Okay. So as I said, we weren't working across those  
24 nations, but I have looked at the witness statements  
25 that you've provided me with, and my impression is

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1 we knew that because of the global evidence of the  
2 importance of the first 1001 days and the impact of  
3 adverse childhood experiences on children. We didn't  
4 take enough notice of the early warnings from the other  
5 nations who were ahead of us in the pandemic, China,  
6 Brazil, and so on. And we didn't take enough notice of  
7 the frontline practitioner intelligence. Very early in  
8 the pandemic, we were writing to the government. We did  
9 surveys, health visitors were telling us -- they were  
10 the eyes and ears on families, they knew the struggles  
11 families were having, and that wasn't taken seriously  
12 enough.

13 It was labelled as anecdotal at the time, so it was  
14 a huge mistake. Health visitors were most needed  
15 working with families. Need went through the roof and  
16 we needed to be out there supporting them in this very  
17 stressful time.

18 **Q.** I'd like to take you now, just to finish, if I could, to  
19 your witness statement, which is INQ000587870, to  
20 paragraph 189, this section here, which I think  
21 encapsulates your evidence on this point.

22 And I'll just read it out, about the role of health  
23 visitors:

24 "... they are the only service that proactively and  
25 systematically reaches all families with babies and

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1 young children who are not afforded the same protections  
 2 that school-age children have from schools. The most  
 3 disadvantaged and vulnerable babies and young children  
 4 are often invisible to other services without an  
 5 effective health visiting service to identify needs and  
 6 risks that may change over time. In our view, whilst  
 7 policymakers did recognise that pandemic countermeasures  
 8 such as lockdown would likely expose children to  
 9 increased risk ... they failed to recognise that health  
 10 visiting would therefore need to play a greater role to  
 11 mitigate the impact of lockdown on the wellbeing and  
 12 safety of babies and young children. At that time,  
 13 health visiting was still categorised as a partial  
 14 'Stop' service. In our view, this decision was  
 15 fundamentally flawed and highlights an essential  
 16 opportunity for learning -- both in preparing for future  
 17 pandemics, and in ensuring safe and effective support  
 18 for families with babies and young children, as part of  
 19 standard practice."

20 Is there anything you'd like to add to that?

21 **A.** It captures it really well. I mean, as far as I'm  
 22 concerned there were three main failings: one was the  
 23 decision to stop the service and to redeploy health  
 24 visitors. The second was this failing of virtual by  
 25 default, which I think lessons needed to be learned

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1 **LADY HALLETT:** And I shall return at 3.20.  
 2 (3.06 pm)

3 (A short break)

4 (3.20 pm)

5 **MS CAYOUN:** My Lady, can you see and hear me?

6 **LADY HALLETT:** I can, thank you, Ms Cayoun.

7 **MS CAYOUN:** Thank you. May I then call the next witness,  
 8 Mr John Barneby.

9 **MR JOHN BARNEBY (sworn)**

10 **Questions from COUNSEL TO THE INQUIRY**

11 **LADY HALLETT:** Mr Barneby, I hope you were warned that you  
 12 would be the last witness of the day, so I hope the wait  
 13 hasn't been too long.

14 **THE WITNESS:** No, it's been fine, my Lady. I've been very  
 15 well looked after, thank you.

16 **MS CAYOUN:** Thank you, Mr Barneby.

17 You have produced a witness statement for  
 18 this Inquiry, I think it is in front of you, and the  
 19 reference that we have for it is INQ000648389.

20 I think you signed that statement on 1 July 2025.

21 Are its contents true to the best of your knowledge and  
 22 belief?

23 **A.** They are.

24 **Q.** Thank you.

25 Mr Barneby, you are the chief executive of Oasis

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1 faster. And the third was when need increased, and we  
 2 knew it had increased significantly, there wasn't any  
 3 measures put in place to strengthen health visiting at  
 4 that time, and there haven't been since, and we've  
 5 continued to see our workforce depleted.

6 **MS POTTLE:** Thank you very much, Ms Morton. That's the end  
 7 of my questions for you. There are no questions from  
 8 Core Participants.

9 Does my Lady have any questions for this witness?

10 **LADY HALLETT:** No, I have no questions.

11 Ms Morton, I appreciate that health visitors may  
 12 feel they're underappreciated, but I'm sure you know,  
 13 those of us who still can remember, 45 years on, the  
 14 comfort of a health visitor when you've got a new baby,  
 15 and of course the benefit for the baby of having a much  
 16 more confident and happy mother. So on behalf of all  
 17 the mothers that you help and the babies that you  
 18 therefore help, thank you very much, and thank you to  
 19 all your colleagues who carried on trying to help people  
 20 during very difficult circumstances.

21 **THE WITNESS:** Thank you, yes.

22 **LADY HALLETT:** Thank you.

23 Very well, we'll take the break now, Ms Pottle,

24 I think.

25 **MS POTTLE:** Yes, that's right, my Lady.

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1 Learning, and I understand you have been with Oasis  
 2 since 2008, and that from 2014 and throughout the  
 3 pandemic you held the role of Chief Operating Officer;  
 4 is that right?

5 **A.** That's correct.

6 **Q.** Thank you. You have told us in your statement that in  
 7 January 2020 Oasis had 52 academy schools under its  
 8 membership and that these were spread across the  
 9 North West and Humber, the West Midlands, London,  
 10 the South West and the South East, and that there were  
 11 30,167 children attending in total; is that right?

12 **A.** That's correct, yes.

13 **Q.** Thank you.

14 And in terms of some of the characteristics of that  
 15 pupil population, I understand that in January 2020, 33%  
 16 of your students were eligible for free school meals,  
 17 which is almost twice the national average at the time  
 18 of 17.3%; is that right?

19 **A.** That is correct, yes.

20 **Q.** Thank you. And 15% of your students had special  
 21 educational needs and disabilities, so roughly  
 22 comparable to the national average at the time, and 32%  
 23 of your children had English as an additional language,  
 24 significantly more than the then national average  
 25 of 19.5; is that all right?

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1 A. That's correct.

2 Q. Thank you.

3 You also tell us in your statement that Oasis  
4 chooses to work in some of the most disadvantaged  
5 communities in the country; is that right?

6 A. That is right.

7 Q. Thank you. Mr Barneby, you may know that we have heard  
8 earlier this week from Sir Jon Coles of United Learning,  
9 and Sir Hamid Patel of Star Academies, both of whom  
10 described the ways in which they were able to get ahead,  
11 so to speak, of planning for school closures even before  
12 government guidance to that effect had arrived.

13 In your case, you tell us in your statement that you  
14 had established your national Covid-19 Taskforce as  
15 early as January 2020. And that you first briefed your  
16 academies about Covid on 5 February 2020. And we  
17 understand from your statement that from that time on  
18 you had a central team able to distill and distribute  
19 guidance. And you tell us, for example, about meeting  
20 regularly on a Sunday night with that team to listen to  
21 government briefings and then decide how you would  
22 communicate key points to head teachers the next day.

23 Can you give us a sense, please, Mr Barneby, of why  
24 that centralised distilling of information was important  
25 for your schools and communities, and perhaps what

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1 A. Yes. So the taskforce that we established, as you said,  
2 met on, typically often on Sundays because that's when  
3 the announcements were made. There was typically a gap  
4 between the DfE guidance coming out, so we had to ensure  
5 that we had really thought out what the announcements  
6 meant, and then, as the questions started to come in  
7 from schools, from parents, we were able to respond to  
8 them. So that national infrastructure that we had made  
9 a massive difference. In terms of IT, you know, we know  
10 that online learning was the only way to really continue  
11 making sure that education was happening.

12 So at the beginning our taskforce, we set out three  
13 priorities: number 1, how do we keep our children and  
14 staff safe? Number 2, we want to go beyond, Oasis as an  
15 organisation, as you say, working in some of the most  
16 challenging areas in the country, and our community  
17 model was key to that, so how do we go beyond the school  
18 to support families and communities?

19 And then number 3: education is not optional. And  
20 that number 3 is where the IT team came in, and where we  
21 were able to take all of our shared laptops or the  
22 student laptops from within schools, around 4,000  
23 devices, to audit all of our family homes for  
24 connectivity and also for equipment availability, and  
25 then to redistribute all of those devices across the

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1 benefit it brought that individual schools might not  
2 have had.

3 A. Yeah, so I think, as you say, we realised fairly early  
4 on, in late January, that, particularly when the virus  
5 came to Italy, that it was not under control or  
6 controllable. And that, we have a fairly mature set of  
7 risk management systems in place, we run disaster  
8 recovery days and continuity planning days. So we had  
9 the mechanisms in place to manage a major event, and so  
10 some of those processes started to kick in and that's  
11 why we formed a Covid taskforce towards the end of  
12 January and then later on turned it into the leadership  
13 team who were actually leading the organisation through  
14 this period. Yeah.

15 Q. Thank you.

16 Another aspect of your organisation that may have  
17 been somewhat unusual in the sector was your seemingly  
18 very large and centralised IT team. You tell us that  
19 prior to the pandemic you had an IT team of 110 staff,  
20 and throughout your statement you describe the ways in  
21 which you leveraged this to manage all aspects of the  
22 shift to online learning and working, and particularly  
23 to provide IT support directly to families.

24 Would it be fair to say, Mr Barneby, that that  
25 central capacity, was key to your pandemic response?

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1 country based on the needs of our students from the  
2 audits.

3 Now, it's one thing to move to online learning, this  
4 is where the gap between policy being created and then  
5 practice on the ground exists. So a lockdown of  
6 schools, a move to online learning as a policy is one  
7 thing. The practice of deploying that equipment, of  
8 telling families, "You can access these online materials  
9 using any devices you've got at home", means that  
10 there's a significant overload of technical support  
11 needed. And so we shifted all of our IT teams, we  
12 created a call centre, and families were able to phone  
13 up for support and this was a critical part of the  
14 beginning of getting children learning through the  
15 myriad devices that we had at the beginning of this.

16 Q. Thank you very much indeed, Mr Barneby, for that  
17 summary.

18 I want to ask you largely about something that may  
19 fall between items 1 and 2 of what you just identified  
20 as your core mission and that is about the approach that  
21 Oasis took towards safeguarding throughout the pandemic.

22 Just before we do that, can I ask, is it right that  
23 in ordinary times, so outside of a pandemic, schools do  
24 play a role in safeguarding but that's largely about  
25 identifying and reporting concerns to children's

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1 services who have the primary statutory responsibility  
2 for safeguarding?

3 **A.** That is not right. So children -- schools play a major  
4 role in safeguarding children every day. So we would  
5 say safeguarding is everyone's business. It is our  
6 number 1 priority to make sure that children are safe.  
7 It is where the trust exists in the education system.

8 As part of that, referrals are made. So  
9 particularly critically vulnerable children, children  
10 missing in education, where we get the signs of domestic  
11 abuse or violence, we're making referrals in to  
12 children's services. But schools play a critical role  
13 in safeguarding all the time.

14 **Q.** Thank you, Mr Barneby. You said a moment ago "it is  
15 where the trust exists". What do you mean by that?

16 **A.** We're trusted, in this case, with 32,000 young people  
17 every day. We're working with some of the most  
18 disadvantaged communities. Often the relationships, the  
19 trusted relationships that form between adults and  
20 children in school, is incredibly important to us  
21 understanding what those children's needs are. You  
22 know, in a holistic sense, not just education, but  
23 socially, emotionally, physically, spiritually. And  
24 then caring for that whole person.

25 So there is an underlying sense of trust and  
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1 please look at page 6 to just consider another part of  
2 the guidance. Thank you.

3 Under the heading "Do vulnerable children have to  
4 continue to go to school?", the Department for Education  
5 set out the expectation that vulnerable children with  
6 a social worker would attend, and said:

7 "In circumstances where a parent does not want to  
8 bring their child to school, and their child is  
9 considered vulnerable, the social worker and the school  
10 should explore the reasons for this, directly with the  
11 parent, and help to resolve any concerns or  
12 difficulties ..."

13 Mr Barneby, would it be right that this guidance  
14 essentially gave rise to a new sort of pandemic-specific  
15 facet of safeguarding work created by the very fact of  
16 school closures, so the job of identifying vulnerable  
17 children and encouraging families to send their children  
18 to school?

19 **A.** So, for schools, vulnerable children have always been  
20 a particular focus area for safeguarding by the very  
21 definition that they are vulnerable.

22 I think we saw an increase in vulnerability, but  
23 also in new categories of vulnerability. So we -- food  
24 poverty became a major issue. Ability to pay utility  
25 bills became a major issue for us. We saw a massive  
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1 relationship that exists that allows that practice to  
2 be -- to be effective.

3 **Q.** Understood. Thank you.

4 With that in mind, then, can we please look at the  
5 guidance that was produced when schools first closed in  
6 March 2020. Thank you very much.

7 For the record, that is INQ000520192.

8 This was the guidance published on 22 March entitled  
9 *Coronavirus (COVID-19): Guidance on vulnerable children  
10 and young people*. And we see here the introduction the  
11 definition that the government had identified for which  
12 children ought to be able to access school placements.

13 I won't linger here, Mr Barneby, because I think  
14 we're all now familiar with that definition.

15 If we can look over the page, please, we see also  
16 the additional category:

17 "We know that schools and other education providers  
18 may also want to support other children who are  
19 vulnerable where they are able to do so."

20 And that is the provision that enabled schools to  
21 have a discretion to identify other children who didn't  
22 fall within the categories we saw a moment ago.

23 And I want to ask you in a moment about how Oasis  
24 went about operating those -- or identifying children  
25 within those categories. But first of all, if we can  
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1 increase -- 50% increases in domestic abuse and violence  
2 over that period of time.

3 So the practice changed, that some of the problems  
4 were -- have always been there in society --

5 **Q.** Thank you.

6 **A.** -- but some of the practices changed.

7 Can I just expand a bit on that? Because we  
8 obviously received this practice, and getting children  
9 back into school, you know, we support the policy of  
10 vulnerable children being in school. That is easy to  
11 say.

12 **Q.** Yes, we're going to come, Mr Barneby, in some detail to  
13 look at exactly how you did that because we want to get  
14 exactly under the skin of why it's easier to say than it  
15 is to do. Just before we get there, the guidance here  
16 envisaged that this was a job for social workers and  
17 schools together.

18 In practice, did you find that it was a joint  
19 endeavour, and that social workers were working together  
20 with schools on this?

21 **A.** So, we -- our referrals to social workers increased  
22 significantly over that period. I don't believe there  
23 was capacity in the system to respond to all those  
24 referrals. There was --

25 **Q.** I'm so sorry, it may not have been clear from my  
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1 question. Let me ask it again. This particular job of  
2 reaching out to families to try to encourage children  
3 who had been identified as children who ought to go to  
4 school, so that narrow task, was that something schools  
5 were being assisted by, by social workers, or should  
6 I interpret your answer to mean that because the system  
7 was under stress, there wasn't that capacity?

8 **A.** I think that's where I was getting to. In reality,  
9 certainly in Oasis, we were making the calls home. We  
10 were doing the work to get the children in. There was  
11 not the capacity in the system for social workers to  
12 fulfil that role, and that's no disrespect to social  
13 workers; they were very busy.

14 **Q.** Yes, thank you very much.

15 Let's start to look, then, at exactly how Oasis did  
16 it. Can we go back to your statement, please, and look  
17 at paragraph 37 of that, which is at page 12. Thank  
18 you.

19 So under the heading "Vulnerability Assessment" we  
20 learn, first of all, about how Oasis identified which  
21 children, in accordance with that guidance, might be  
22 offered a place at the school. You say:

23 "... we had significant concerns about the safety  
24 and welfare of our pupils during the lockdown period.  
25 During the Covid-19 period an additional section was

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1 "Those children classed as 'vulnerable' under an  
2 Oasis definition of vulnerability including, but not  
3 limited to, other safeguarding issues, young carers,  
4 victims of domestic abuse, food poverty issues,  
5 et cetera."

6 I think that this is your interpretation of that  
7 otherwise vulnerable category that we looked at in the  
8 guidance. How did you go about expanding on this? Was  
9 it based on what you already knew about your pupil  
10 population?

11 **A.** Yes, so all our Designated Safeguarding Leads, our DSLs,  
12 worked throughout Covid, often in school, and we applied  
13 this dynamic risk assessment approach, so we would take  
14 everything we knew, the categorisation of children  
15 formally, and then everything we knew about the families  
16 and then we would effectively RAG rate children based on  
17 that. So if you were red you were considered critical  
18 support needed, and we would ensure that you would have  
19 a call every day. At home, we would have you in  
20 school --

21 **Q.** It might just help, Mr Barneby, if we can have, please,  
22 paragraph 38 of your statement on the screen as we go  
23 through this because I think you have set out some of it  
24 there.

25 **A.** Yes, thank you.

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1 identified within our approach to safeguarding ..."

2 And carrying on, you say:

3 "Each of the academy Designated Safeguarding Leads  
4 ... were instructed to undertake dynamic risk  
5 assessments on all pupil lists against four categories  
6 of vulnerability ..."

7 And we see there the four categories.

8 I have a number of questions about this. First of  
9 all, we saw from the guidance a moment ago, and we know  
10 that there was provision for children with education,  
11 health and care plans to attend. You have included here  
12 also those who were in the progress of getting an  
13 education, health and care plan. Why is that?

14 **A.** So there was often delays to children actually receiving  
15 these plans, when we understand that the needs are  
16 there. Given the situation that we were in, we thought  
17 it was best, and again, going back to those principles  
18 of the Covid taskforce, how do we keep children and  
19 families safe? Our number 1 principle. And then that  
20 principle of education is not optional. And so that  
21 combination meant that we applied more generous  
22 approaches to making sort of categorisation of  
23 vulnerable children to make sure that we had as many  
24 children as possible in the school.

25 **Q.** Thank you. The next bullet point says:

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1 So where children were deemed through this risk  
2 assessment process, to have a critical vulnerability,  
3 including our own categories of vulnerability, then we  
4 would ensure we had contact every day. Our preference  
5 was to have children in school who were red category,  
6 but equally, some of those children are the hardest to  
7 access, as well.

8 Then children who were amber, calls were required  
9 every two to three days, and those that were green,  
10 every four to five days.

11 In total we made 118,000 calls between lockdown 1  
12 and 2, and indeed, when we look at our attendance, you  
13 know, we were at 33% of vulnerable children attending  
14 schools regularly compared to a national of 9%.

15 **Q.** We're going to come in a moment to look at that --

16 **A.** One of the things that we did that made this  
17 successful --

18 **Q.** Mr Barneby, I am so sorry. I don't want to interrupt  
19 you, I just want to go through it in stages so that we  
20 have everything we need about exactly how you did that.

21 I just want to ask you for a moment about that  
22 dynamic risk assessment because one of the things we  
23 read from your statement is that that was undertaken on  
24 your entire pupil roll, so 30,000 pupils. So does that  
25 mean that your safeguarding leads were not just looking

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1 at the children they already thought might be  
 2 vulnerable, they in fact took a fresh look at all  
 3 children and thought about whether they might now be  
 4 vulnerable?

5 **A.** Yes, so it's a combination of our safeguarding leads,  
 6 pastoral staff, teachers. What did we know about those  
 7 families? And again, this principle of how do we keep  
 8 our children safe through this? And as we say, we did  
 9 that work to review against statutory categories and  
 10 then our broader understanding as well.

11 **Q.** One of the concerns that we know that the Children's  
 12 Commissioner raised at this time, because we heard  
 13 evidence from her last week, was that it might all -- it  
 14 might not always be known in schools exactly what  
 15 a child's circumstances were, sometimes local  
 16 authorities had information about children that weren't  
 17 making their way into schools. How were you satisfied  
 18 that your designated safeguarding leads had everything  
 19 they needed to be able to undertake that dynamic risk  
 20 assessment?

21 **A.** Well, you'd go off the information that you've got  
 22 available to you. I think schools have a uniquely  
 23 trusted relationship with families. It is, when you  
 24 think about society, it's the only bit of social  
 25 infrastructure that exists in almost every community.

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1 attributed to that is some of the technological changes  
 2 that we made.

3 **Q.** Mm-hm.

4 **A.** And we shifted our phone system from the school into  
 5 teachers' homes, so that they could use the school  
 6 number to make the calls home.

7 When we did that, the percentage of parents  
 8 answering the call from this trusted number, versus an  
 9 unknown mobile, increased significantly, and that  
 10 allowed our contact with families to be more effective.

11 And then through -- as I say, if we couldn't get  
 12 hold of a family, we would complete a home visit. We  
 13 had a clear protocol for keeping our staff safe during  
 14 those home visits, and equally to help parents  
 15 understand what those visits were about. You know,  
 16 there was a stigma attached to being considered  
 17 a vulnerable family that -- that people started to know  
 18 about and we were acutely aware of positioning our home  
 19 visits to not make that a thing.

20 The other thing, we were very careful about keeping  
 21 our staff safe as well, and so those protocols would  
 22 control how staff entered a house, if they needed to,  
 23 but also how they decontaminated when they came back as  
 24 well, to make sure that the virus wasn't taken into  
 25 a home environment or back into the school.

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1 It's the only bit of social infrastructure that families  
 2 and children proactively visit on a daily basis. So our  
 3 understanding, through those relationships, of children  
 4 and families and things going on in children's lives is  
 5 significant. And so it was that understanding and  
 6 knowledge that we applied into that risk assessment  
 7 process.

8 Of course, when we are speaking to other agencies  
 9 and making referrals we are using some of that knowledge  
 10 as well.

11 **Q.** Thank you.

12 You went on then, and I'm sorry to have cut you off,  
 13 to tell us about the keeping in touch calls and the home  
 14 visits, and we learn from this paragraph that if a child  
 15 was not -- and I'm sorry, it may be the rest of the  
 16 paragraph, which is over the page -- that if a child was  
 17 not attending remote learning or if their family wasn't  
 18 picking up the phone for those keeping in touch calls,  
 19 that's when you would conduct a home visit; is that  
 20 right?

21 **A.** Yes. So, as I say, we made just over 118,000 calls  
 22 home. One of the reasons -- and I was just chatting  
 23 about the percentage of children attending -- vulnerable  
 24 children attending our schools, at 33% attending  
 25 regularly versus the national 9%, one of the things we

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1 **Q.** Thank you, Mr Barneby. You've spoken with great  
 2 precision about some of those statistics on, for  
 3 example, the number of calls, and we know from your  
 4 statement that you were able to do so because you kept  
 5 very careful data, and collected it nationally, to  
 6 understand what was going on. And you have exhibited to  
 7 your statement, a report from July 2020, all of that  
 8 data.

9 If we can look at that, please, it's at  
 10 INQ000643927. Thank you very much.

11 Before we look at some of it, we see from the first  
 12 paragraph, last sentence there, that you say:

13 "Throughout this report there is a distinction made  
 14 between 'vulnerable children', as defined in both  
 15 [Her Majesty's] Government advice and the OCL categories  
 16 and those who are 'clinically vulnerable' to coronavirus  
 17 due to underlying medical conditions and/or shielding  
 18 because of family members."

19 Can you explain that, please. Was there  
 20 a difference in how you monitored and supported those  
 21 with clinical vulnerabilities, as opposed to how you  
 22 monitored and supported those with safeguarding  
 23 vulnerabilities?

24 **A.** Yes, so we were obviously very keen to get safeguarding  
 25 vulnerable children into school wherever possible.

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1 Clinically vulnerable children, we needed to take a very  
2 approach, by the very nature of the impact of them  
3 catching Covid could have been significantly more  
4 serious. And so our support around them was ensuring  
5 that they had the resources and capacity at home to take  
6 part in home learning, to make sure that food wasn't  
7 a significant issue in their families, to think about  
8 how we were supporting the wider families as well.

9 **Q.** Thank you.

10 If we now come, then, to look at the graph that's on  
11 this page, it's headed "Number of vulnerable children  
12 across OCL".

13 And I think that the different coloured bars show us  
14 the numbers as they were across time, so the light blue  
15 is 6 April and the green is 13 July.

16 And what we can see here is that, by some  
17 considerable margin, there are more children in the  
18 category of "Other Vulnerabilities", and thinking back  
19 again to the guidance and then to your statement,  
20 I think this is the Oasis group of identified  
21 characteristics about vulnerability rather than any of  
22 the government guidance groups.

23 Just reflecting on that, does that suggest to you  
24 that the government's definition of which children were  
25 vulnerable was lacking at all? Or perhaps, on the other

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1 first heading "Domestic abuse/violence", you say that:

2 "Since [the week commencing] 6 April, this group has  
3 seen the largest increase of any ... a 50% increase."

4 If we can look next at "Food poverty", the second  
5 bullet point there. Again:

6 "Since [the week commencing] 6 April, children  
7 considered vulnerable due to food poverty has increased  
8 by almost 200 ..."

9 Again, if we can look under the next heading "Other  
10 Vulnerability":

11 "The largest vulnerability group in all the lockdown  
12 weeks has been children classified as 'Other  
13 Vulnerability'. This week the 'Other Vulnerability'  
14 group has increased by 58."

15 And we learn that:

16 "The increases are largely driven by mental health  
17 issues of both parents and children."

18 Was this information, Mr Barneby, being gleaned from  
19 those keeping touch with phone calls and home visits?

20 **A.** Yes.

21 **Q.** And what does it tell you -- if this isn't too obvious  
22 a question, what does it tell you as a school or as  
23 a group of schools about what your children were  
24 experiencing in those weeks of lockdown?

25 **A.** I think it was incredibly challenging for children, for

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1 hand, does it suggest to you that the flexibility  
2 afforded by that final category was particularly  
3 important?

4 **A.** I think that the latter option: the -- the flexibility  
5 of that category allowed us to give agency to local  
6 leaders on the ground to assess which children they felt  
7 needed additional support and then, through that  
8 risk assessment process, to then allocate that support  
9 accordingly.

10 It feeds back into what Oasis is about. It's  
11 a fundamentally -- we are about communities, about going  
12 that extra mile for our communities. Education is one  
13 key part of that. And I think that was borne out in the  
14 way that we managed this.

15 **Q.** Thank you.

16 If we can look at now I think it's page 3 of this  
17 document. Apologies, I'm taking it slightly out of  
18 order, thank you.

19 These are some of the statistics that you referred  
20 to earlier -- I'm so sorry, it's page 2 in fact. Thank  
21 you very much. If we can slightly zoom out so we can  
22 see the heading. Thank you very much indeed.

23 These are some of the aspects of what you were  
24 learning, I think, about your children's circumstances  
25 that you talked about earlier. So we can see, under the

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1 families. The social infrastructure that was available  
2 for children was no longer available in quite the same  
3 way. We have a number of families that are seasonal  
4 workers that didn't have furlough, so income streams  
5 stopped. Living conditions weren't adequate in some  
6 households -- normally, let alone in lockdown. And then  
7 access to technology was extremely limited for some  
8 families as well.

9 In fact I was in one of our schools just after  
10 lockdown 2 ended -- actually working on reception, I was  
11 working at some of our schools to make sure I understand  
12 what's going on -- and I met a mum there, who came in  
13 and had just had her mobile phone -- would have just had  
14 her mobile phone, and she came in and said thank you.  
15 And we had issued six laptops -- six iPads to her, one  
16 for every child, and as a result, she'd been able to  
17 access online learning and had been able to get through  
18 this. And she was saying, "I just don't know how we  
19 would have done it. I don't know how our children would  
20 have been able to access learning, would have been able  
21 to speak to their friends, would have been able to  
22 continue with a degree of normality."

23 **Q.** Thank you. Can we look then at page 3, where we were  
24 earlier. This is a table that shows us, as at  
25 July 2020, the proportion of vulnerable children that

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1 were attending at your schools. And we see highlighted  
2 in green there, and that's the green from the original  
3 document, that 18 of your schools, I think, had over 50%  
4 of their vulnerable children attending. And indeed, at  
5 the top, some very high numbers: 100, 94, 93 per cent.

6 There is a decrease, and we won't go there, but on  
7 the next page there's a figure that's as low as 7%. So  
8 there was clearly quite a range. As you say, the  
9 average, I think, was 33%, so considerably higher than  
10 the national average at the time.

11 So the first question then, Mr Barneby, is how --  
12 what was happening in those schools that were managing  
13 to reach 100 or 94 or 93%? What were they doing that  
14 was so effective to get vulnerable children into school?

15 **A.** So I hope you can see, firstly, from this report -- this  
16 was a report that we used to regularly get in from our  
17 safeguarding teams. We took this very seriously. And  
18 as a result of that, we were monitoring, we were  
19 receiving regular reports and monitoring and then  
20 following up and supporting schools where they weren't  
21 successfully getting children in.

22 There are so -- it's a very complex answer to your  
23 question because there's so many variables around what  
24 was allowing vulnerable children to come in or not come  
25 in. What we know is that the regular calls home, the

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1 were in, was perhaps the biggest influencing factor as  
2 to whether vulnerable children were coming in or not.

3 **Q.** That sounds entirely fair, Mr Barneby. Let me explain.  
4 The reason that I ask is because you will be aware that  
5 part of this Inquiry's role is to make recommendations  
6 about preparing for a future pandemic or a civil  
7 emergency. And in a future emergency, it's conceivable  
8 that there would be a need again to identify vulnerable  
9 children, and to create a process for ensuring that  
10 those children had access to a place of safety.

11 And so I'm wondering whether, based on your  
12 experience, there is anything that we can extrapolate  
13 for the bigger picture?

14 **A.** I think it is a rigorous daily approach, you know,  
15 a belief that we can get these children, that we won't  
16 give up, we won't stop, even when they don't answer the  
17 calls, when they don't respond, you know, when -- we  
18 will go there and we will try and establish if families  
19 are in the homes or not. And I think it is that  
20 constant, relentless focus on safety and safeguarding  
21 that allowed us to be significantly above the national  
22 position.

23 **Q.** Thank you, Mr Barneby.

24 I've been passed a note to say that you and I both  
25 need to slow down a little bit so I apologise and if you

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1 home visits, the infrastructure that we had, the advice,  
2 that we were providing as a national team to DSLs, the  
3 things that they were telling us that was working and we  
4 were sharing across the organisation, meant that we were  
5 able to gradually increase the number of vulnerable  
6 children coming in.

7 **Q.** And do you know -- this might be too much of a detailed  
8 level -- but do you know what those schools were doing  
9 so well? Was it something in the conversations? Was it  
10 the relationships? Clearly there's a range, and yet the  
11 central management and the messaging appears to have  
12 been the same because it was the same central management  
13 team? So what was the difference, Mr Barneby, between  
14 those who were doing it very well, and those who were  
15 struggling?

16 **A.** So I think all of our schools did a fantastic job in  
17 this area, that's the first thing, I think our  
18 Designated Safeguarding Leads are -- deserve a huge  
19 amount of gratitude for the work that went on.

20 There are two sides to this. There is the work that  
21 the school is undertaking and then there are decisions  
22 that families are making as well. And I think your  
23 presentation of this data to say that a difference in  
24 terms of what was going on in the schools leading to the  
25 result of this, I think the circumstances that families

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1 could also please speak a bit more slowly.

2 Just one more graph amongst this data, please, if we  
3 can look at page 6. Here at the top we have a graph  
4 that shows the number of home visits that were being  
5 undertaken, and just to remind us, I think we said  
6 earlier that home visits were undertaken if a child had  
7 a high, to put it bluntly, RAG rating and if they  
8 weren't presenting for remote learning and if keeping in  
9 touch calls were not answered.

10 We can see here some quite clear trends. So in  
11 June of 2020 there seems to have been quite  
12 a significant spike in the number of home visits that  
13 were necessary and also -- did I say June? I meant May.  
14 Clearly we have a spike in May and June.

15 Are you able to help us understand the reason for  
16 those spikes, please?

17 **A.** Yes, I think initially -- I think as Covid, as the  
18 lockdowns went on, the challenges of being at home  
19 became greater and greater and we saw more disengagement  
20 and as a result of that, the home visits increased.

21 **Q.** Thank you.

22 I want to move on now to the related topic, please,  
23 of children missing out on education. Can we look,  
24 please, at paragraph 45 of your statement. You say  
25 here:

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1 "A distinction was made during lockdown between" --  
2 I'm sorry, let me give the reference. It's  
3 INQ000648389, and it's page 14. Thank you,  
4 paragraph 45.

5 You explain that:

6 "A distinction was made during lockdown between  
7 children who were missing out on their education ...  
8 because of a refusal to engage in home learning and  
9 those children deemed missing from education under the  
10 statutory guidance."

11 Can you explain that to us, please?

12 **A.** Yes, so children missing from education relates to  
13 children who we have not seen, we've not been able to  
14 contact for a certain period of time, typically ten  
15 days, and we complete a series of relevant checks to try  
16 and track those children down, and then after that  
17 ten-day period we typically report that as a child  
18 missing in education to the local authority, and in  
19 normal circumstances after a certain additional period  
20 of time, typically another ten days, they would come off  
21 roll, so that's children missing on education.

22 Children missing out on education, which was one of  
23 the biggest challenges is where children were either  
24 engaging at the beginning and then stopped engaging, or  
25 didn't engage at all. So they were missing out on the  
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1 **A.** It certainly is -- has had an impact on children's  
2 educational needs. The mental health and wellbeing  
3 fragility of children that do have Long Covid clearly  
4 has an impact on them coming into school. We see  
5 increased, you know, emotional school avoidance, and  
6 yeah, every day that they miss is a challenge.

7 **Q.** Thank you. Another group of children whose attendance  
8 may have been impacted differently to others are those  
9 children who have or had a clinical vulnerability to  
10 Covid-19, or who lived with a family member with  
11 a clinical vulnerability and who were, therefore,  
12 understandably worried about contracting the virus.

13 Since 2020 -- I beg your pardon, since  
14 September 2020, it's been the policy of the Department  
15 for Education to mandate attendance unless a child is  
16 designated as being unable to attend by their doctor.

17 Some families have taken the view that they don't  
18 feel able to send their children to school if they  
19 consider it unsafe to do so, perhaps even without that  
20 medical certification, because they're worried about  
21 vulnerability to Covid-19, either of their child or  
22 someone in the household. Have you been aware yourself  
23 of that as a particular concern affecting attendance?

24 **A.** No.

25 **Q.** Thank you.

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1 learning, rather than actually -- we knew where they  
2 were, we knew they were safe, but they weren't  
3 necessarily engaging in learning.

4 **Q.** One group of children who may have missed more education  
5 than others, perhaps both in terms of remote learning  
6 during school closures and in-person learning when  
7 schools opened, is those who contracted Long Covid.  
8 Were you, Mr Barneby, or are you aware, of Long Covid  
9 having been an issue affecting attendance in your  
10 schools?

11 **A.** I don't think we knew that much about Long Covid at that  
12 time. So I think we were looking at clinically  
13 vulnerable children as a category. I don't think we  
14 were really -- I don't think we had that understanding  
15 of the impact of Long Covid at that stage.

16 **Q.** And do you recall -- perhaps I should take from your  
17 answer that the answer to this is going to be "no", but  
18 do you recall receiving at any stage guidance or  
19 information about Long Covid in relation to how to  
20 identify it, how to support pupils with it, in managing  
21 their symptoms or extra educational needs?

22 **A.** No.

23 **Q.** And are you now able to say whether Long Covid is having  
24 an impact on children's educational needs or equally, is  
25 that not something that is being monitored?

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1 Turning then to the broader issue of attendance, can  
2 we look, please, at page 58 of your statement. Thank  
3 you very much.

4 We see here some tables explaining changes in the  
5 rate of attendance between the year before the pandemic,  
6 and between the last complete academic year. And I want  
7 to ask you particularly about table 20, please. That is  
8 about rates of persistent absence.

9 What is persistent absence, please?

10 **A.** Persistence absence is children who are attending school  
11 less than 90%.

12 **Q.** Less than 90%. Thank you. And why is that a metric  
13 that matters?

14 **A.** Below 90% has a significant impact in children's  
15 outcomes.

16 **Q.** Thank you.

17 And we see that the difference is quite significant  
18 in the year before the pandemic as compared to last  
19 year. So we see Oasis Community Learning, 2018-19, at  
20 just under 10%, and now just over 20%. So that is  
21 a doubling at primary level.

22 And if we can look over the page, please, at  
23 table 22, that is the same statistic for secondary  
24 school, and we see, again, a very significant increase  
25 in persistent absence in the year ending 2019, to the

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1 last academic year.

2 Just looking at this table, would we be right to  
3 understand from that that one in three secondary  
4 students are missing 10% of the school year?

5 **A.** Basically stated, that's correct, yeah.

6 **Q.** And what do you understand are the key drivers of that  
7 trend?

8 **A.** There's a range of issues, and fundamentally, the  
9 relationship between schools and families has changed,  
10 and we've spent a lot of time working with families to  
11 help them understand the importance of being back in  
12 school.

13 There are a number of -- we talk about Long Covid.  
14 There's Long Covid clinically as a disease and then  
15 there's Long Covid, the impact on people. And as I said  
16 earlier, the impact of being at home, particularly for  
17 disadvantaged families, was significant. You know,  
18 mental health, we saw a huge increase, to the extent  
19 that we have invested now in a mental health team as  
20 a result of trying to help get children back into school  
21 and to support children to regularly attend again.

22 Anxiety, emotional school-based avoidance, are  
23 really key long-term issues that we are continuing to  
24 try to solve.

25 **Q.** As well as telling us about your National Mental Health  
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1 school?

2 So Oasis Encounter brings together parents in small  
3 groups, allows them to share the stories and challenges  
4 that have been going on, and then we provide a series of  
5 inputs that help parents navigate these issues, and  
6 equips them to work with us to bring children back into  
7 mainstream education again.

8 **Q.** And I think you said you've had some success with that.  
9 Did you mean that that is improving attendance  
10 statistics?

11 **A.** Yes, significantly. I forget the exact stat but it's  
12 a significant increase in children that have been  
13 through, and parents being through Oasis Encounter are  
14 now reengaged back into school.

15 **Q.** Thank you. On a different topic you have also explained  
16 in some detail in your statement the challenges that  
17 your schools faced, for example, with obtaining PPE,  
18 implementing social distancing, implementing testing,  
19 and being able consistently to implement cleaning  
20 regimes. I think you even tell us it was difficult at  
21 times to find enough cleaners to be able to carry out  
22 what you needed to.

23 I want to ask you about your experiences of managing  
24 ventilation in buildings. You tell us something about  
25 the challenges of doing that, both in old buildings and  
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1 Team in your statement, you describe the Oasis Encounter  
2 scheme, which delivers therapeutic work not just for  
3 children but for families. And it seems, if I've  
4 understood it correctly, sometimes for parents in  
5 particular. Is that a post-pandemic phenomenon? And if  
6 so, what should we understand from that?

7 **A.** Yes, so Oasis Encounter is a programme that supports  
8 parents primarily, but also children as well, in helping  
9 them re-engage with education again. And we've had  
10 quite significant success through this. It worked by  
11 helping parents understand some of the reasons. So, for  
12 parents, the presentation in a child of not attending  
13 school might be "I don't want to go to school, I don't  
14 like it" --

15 **Q.** I'm so sorry, Mr Barneby, I'm going to ask you again  
16 just to slow down a little.

17 **A.** Sorry.

18 **Q.** Thank you very much.

19 **A.** The issues presenting themselves to parents around  
20 children not attending school might well be their child  
21 saying, "I don't want to go to school, I don't like  
22 school, I don't want to attend, I don't need to go", and  
23 trying to help parents understand the thing that is  
24 behind that. So what is the anxiety or thing that is  
25 actually preventing that child from wanting to go into  
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1 in new buildings. The main question is, what lessons  
2 can we draw from your experiences in order to improve,  
3 if possible, ventilation in school buildings for the  
4 future?

5 **A.** Yeah, so we faced, I think like many schools, we had the  
6 CO<sup>2</sup> monitors in place. We followed the protocols that  
7 are available to us. Typically in the older buildings  
8 it meant opening windows, and that created all the  
9 challenges around running the heating, keeping children  
10 warm. We had people sitting in coats in rooms trying to  
11 get the ventilation to be satisfactory. That is not  
12 a great learning environment. So that's the old  
13 buildings.

14 The new buildings, many of them are built with  
15 passive ventilation systems. They don't necessarily  
16 move air around at the right pace. Some of our new  
17 buildings don't have windows that open, so you are  
18 relying on this passive ventilation system to move air  
19 around the building, which has varying degrees of  
20 effectiveness.

21 The thing I think we need to learn is that the  
22 environment of classrooms is critical to children  
23 learning. And so ventilation during Covid is one issue  
24 of managing that, but there is a bigger picture issue  
25 around having effective school buildings, having  
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1 classrooms where the temperature is right, and suitable  
2 for learning, and I think we could probably, if we went  
3 and looked back at the data, start to track  
4 correlational between outcomes and attendance based on  
5 the quality of school buildings and the environments.

6 **Q.** Thank you, Mr Barneby, I'd like to turn now to your  
7 conclusions and what you say are some of your lessons  
8 learned for the future. You make a number of points in  
9 your statement and I won't go through them all, but one  
10 that I want to ask you about, because I don't think  
11 anybody else has raised this, is something that you call  
12 the Benefits of PedTech. Can you explain, please, what  
13 that is and why you think it might be important in the  
14 future?

15 **A.** So just to set the scene, so by the end of Covid, we had  
16 deployed 32,000 iPads. We had a universal offer of  
17 education, and then when you have a single platform in  
18 every home, you can target, you can create a coherent,  
19 online education system. So the thing about doing that  
20 is that there is a change in pedagogy that's required.  
21 So teaching to a class where you can see people is one  
22 approach; teaching online changes the way that  
23 assessment works, the way that tasks are being set, and  
24 the way that you manage conversations. Indeed, some of  
25 the curriculum that is suitable to be taught online, the

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1 communities that we serve was to make sure as we go into  
2 this next industrial revolution, which is AI and  
3 robotics, that our children don't get left behind.

4 And because we've had this strategy thinking going  
5 on, we've already had a plan to deploy one-to-one  
6 devices. And so as Covid hit, we were able to pick up  
7 that plan and start deploying the devices out. It's  
8 what allowed us to bring online learning, you know, on  
9 much quicker than many others.

10 **Q.** Thank you very much, Mr Barneby. Was there, I think,  
11 anything else that you wanted to say by way of lessons  
12 learned or overall reflections?

13 **A.** I think overall we talk about school closures; our  
14 schools didn't close. Schools were not closed. You  
15 know, you've seen 33% of vulnerable children in school.  
16 You know, head teachers I spoke to, they worked harder  
17 than they'd ever worked. DSLs worked harder than they'd  
18 ever worked. Teachers that weren't in school were  
19 working. So this idea of the school building or the  
20 school being closed wasn't the reality on the ground.  
21 And I think I would end just by saying, you know, a huge  
22 thank you to Oasis staff, but actually to the wider  
23 education profession for -- for keeping our children  
24 safe, for trying to minimise the impact on learning of  
25 children, and their future careers and opportunities.

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1 way that breaks need to happen. And so PedTech is this  
2 concept of really thinking about the deployment of  
3 technology for the purpose of learning rather than the  
4 deployment of technology.

5 So how do you actually line up an approach to  
6 teaching that fits with the technology that's deployed?  
7 And that's something that we spent a lot of time as we  
8 were deploying the technology across Oasis, of training  
9 our teachers, of making sure that they were equipped to  
10 maximise what was a very considerable investment that we  
11 made.

12 Part of our thinking behind that and the reason that  
13 we were able to mobilise such a large-scale deployment  
14 was that we were already thinking about this. We  
15 already had a view that at some point the -- children  
16 will need a device to maximise their education, just  
17 close down that digital divide, and if we look in  
18 society, if anyone has studied economics, you will know  
19 that whenever there is an industrial revolution in this  
20 country, two things need to happen: number 1, the  
21 education system has to change itself, has to develop  
22 the skills that people need; and number 2, the gap  
23 between those that have and those that have not, gets  
24 wider. Every time.

25 And I think part of our approach in Oasis for the  
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1 **MS CAYOUN:** Thank you very much, Mr Barneby. Those are all  
2 my questions, and there are no questions from any Core  
3 Participant.

4 My Lady, do you have any questions?

5 **LADY HALLETT:** Thank you very much indeed, Mr Barneby.  
6 You're an evangelist of the best kind.

7 **THE WITNESS:** Thank you, my Lady.

8 **LADY HALLETT:** You obviously believe wholeheartedly in what  
9 you're doing, and obviously we all echo the efforts made  
10 by people like your staff to keep children safe and to  
11 keep them learning.

12 Can I ask, what is the funding model for Oasis? Is  
13 it government funding? Central funding?

14 **A.** Yes, so -- so, Oasis is a group of charities, and one of  
15 those charities is Oasis Community Learning, which is  
16 what we've been talking about today, and Oasis Community  
17 Learning runs, now, 56 schools across the country. And  
18 there are other charities -- so the vision for Oasis is  
19 a vision for community, and education is one part of  
20 that.

21 And alongside that we run Stop the Traffik that's  
22 trying to prevent people trafficking.

23 We run Oasis Restore. That's the new secure school  
24 that's trying to change the question around young  
25 people's social justice, to say -- rather than saying

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1 "What did you do?", saying "What happened to you?"  
 2 How is this 11-, 12-, 13-year-old locked up? What's  
 3 happened to that child?  
 4 We run food banks, food pantries. We do debt advice  
 5 work, family support work. And it is this integration,  
 6 the holistic offer brought together around a hub,  
 7 including the school, that provides what we think is  
 8 this, sort of, piece of social infrastructure, this  
 9 village, if you like, that allows children and families  
 10 to thrive, that gives some of the most disadvantaged  
 11 communities that -- that advantage, that social justice,  
 12 to help them have the same opportunities that many of us  
 13 in this room have had.  
 14 **LADY HALLETT:** Very worthwhile cause.  
 15 Thank you very much indeed, Mr Barneby, for all that  
 16 you're doing at Oasis, and thank you for all the help  
 17 you've given to this Inquiry. It's been a very  
 18 interesting afternoon. Thank you.  
 19 **THE WITNESS:** Thank you, my Lady.  
 20 **MS CAYOUN:** My Lady, that concludes the evidence today.  
 21 **LADY HALLETT:** Thank you, Ms Cayoun. I shall return  
 22 tomorrow for a 10.00 start.  
 23 **(4.10 pm)**  
 24 **(The hearing adjourned until 10.00 am the following day)**  
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97/20 168/15  180/13 182/24 189/9  203/15  <b>35 [2]</b> 146/21 147/23  <b>35,000 [1]</b> 25/5  <b>360 [1]</b> 77/6  <b>37 [1]</b> 177/17  <b>38 [2]</b> 145/15 179/22  <b>38 weeks [1]</b> 152/19  <b>39 [1]</b> 157/9</p> <hr/> <p><b>4</b></p> <p><b>4,000 [2]</b> 81/2 171/22  <b>4.10 [1]</b> 205/23  <b>40 [2]</b> 84/13 117/2  <b>40.1 [1]</b> 157/9  <b>42 [1]</b> 141/14  <b>43 [1]</b> 77/3  <b>431 [1]</b> 34/24  <b>433 [1]</b> 33/2  <b>434 [1]</b> 34/11  <b>436 [1]</b> 34/25  <b>439 [1]</b> 37/3  <b>441 [1]</b> 37/9  <b>443 [1]</b> 37/18  <b>45 [2]</b> 192/24 193/4  <b>45 minutes' [1]</b>  127/15  <b>45 years [1]</b> 166/13  <b>45-second [1]</b> 156/11  <b>450 [1]</b> 110/14  <b>46 [1]</b> 84/13  <b>49 [2]</b> 46/3 147/14  <b>49.3 [1]</b> 103/9</p> <hr/> <p><b>5</b></p> <p><b>5 February 2020 [1]</b>  169/16  <b>5-9 [2]</b> 40/25 41/13  <b>5-year-olds [1]</b> 39/14  <b>50 [6]</b> 80/14 111/24  161/16 176/1 187/3  189/3  <b>50,000 [1]</b> 23/15  <b>500-699 [1]</b> 147/15  <b>51 [1]</b> 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<b>H</b>	<b>I couldn't [1]</b> 62/9	<b>I put [1]</b> 75/16	131/6 131/24 203/21	11/14 12/6 12/11 13/8
<b>hubs [5]</b> 45/15 45/16 45/21 49/1 49/7	<b>I did [1]</b> 71/24	<b>I read [1]</b> 22/2	<b>I wouldn't [4]</b> 61/21	13/18 14/4 14/15 15/3
<b>huge [16]</b> 7/15 68/22 95/14 98/21 113/24 128/5 153/6 155/12 156/15 157/12 159/4 162/4 164/14 190/18 197/18 203/21	<b>I didn't [4]</b> 70/14 106/17 116/4 130/3	<b>I remember [1]</b> 140/6	61/23 61/25 85/5	15/8 15/15 15/16
<b>hugely [2]</b> 76/23 100/13	<b>I do [6]</b> 77/21 98/24 105/12 106/25 107/11 141/1	<b>I represent [1]</b> 104/11	<b>I'd [26]</b> 6/1 19/6 22/11 28/25 33/1 34/9 42/24 72/24 92/7 112/17 114/14 116/7 117/3 117/6 122/6 125/23 130/8 138/3 142/13 145/4 147/2 153/9 155/2 162/20 164/18 201/6	15/19 16/17 19/19 23/14 23/16 26/19 26/20 27/18 29/3 29/17 32/2 33/6 33/9 34/11 34/24 35/2 36/3 36/12 37/15 38/16 40/16 41/2 41/19 42/5 43/21 47/4 49/10 50/1 50/5 50/7 50/7 53/16 54/6 57/1 61/17 62/1 63/12 63/23 65/16 67/7 69/22 70/5 70/13 71/19 74/4 74/16 76/9 77/21 77/25 79/23 79/25 80/8 80/20 80/25 84/4 85/25 87/15 87/24 89/21 90/21 92/16 93/10 93/16 94/10 94/11 95/1 95/2 95/16 95/21 97/6 98/8 99/18 101/7 102/7 102/7 102/12 102/19 102/20 102/23 105/14 105/16 106/8 107/11 107/17 108/25 109/2 115/21 117/10 118/14 118/22 119/1 119/16 123/11 123/24 124/11 125/4 127/4 128/21 129/6 129/17 129/20 130/19 133/19 134/22 134/23 136/2 137/9 137/10 137/11 139/2 142/23 143/3 145/12 147/25 148/17 148/25 149/4 149/7 152/20 154/5 156/14 159/23 162/11 162/20 164/18 174/15 174/25 179/17 179/21 182/14 182/16 182/17 183/11 183/22 184/9 185/10 186/16 186/21 187/4 187/9 187/21 191/18 191/25 192/2 192/6 192/7 192/8 195/18 196/22 198/3 198/5 200/3 201/2 202/17 202/18 205/9
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<p><b>W</b></p> <p><b>we've [29]</b> 3/24 17/18 27/17 28/10 30/16 31/14 42/19 50/8 50/10 51/16 54/12 55/14 57/8 68/16 71/4 75/20 126/1 135/6 141/13 147/5 147/5 148/17 166/4 193/13 197/10 198/9 203/4 203/5 204/16</p> <p><b>webinars [1]</b> 48/8</p> <p><b>website [1]</b> 153/24</p> <p><b>Wednesday [1]</b> 1/1</p> <p><b>week [11]</b> 9/19 120/4 136/24 152/6 152/9 152/20 169/8 181/13 187/2 187/6 187/13</p> <p><b>weeks [16]</b> 9/14 10/15 11/4 11/18 15/3 34/14 34/16 43/6 94/10 137/3 143/13 151/17 152/6 152/19 187/12 187/24</p> <p><b>weigh [2]</b> 36/15 154/9</p> <p><b>welcome [4]</b> 66/5 98/2 109/5 132/18</p> <p><b>welcomed [1]</b> 95/7</p> <p><b>welfare [2]</b> 74/10 177/24</p> <p><b>well [82]</b> 4/10 4/24 10/14 13/8 15/19 15/22 16/22 16/25 18/1 18/8 24/2 25/18 26/9 27/3 27/15 27/22 29/24 30/24 31/11 31/18 32/3 33/17 33/19 33/21 35/24 36/11 47/6 55/1 56/6 56/10 57/7 58/12 60/16 68/21 69/7 69/20 75/14 82/2 85/25 93/20 94/8 95/1 95/13 96/2 96/7 105/15 107/8 109/2 109/6 113/8 117/21 117/24 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<p><b>W</b></p> <p><b>why... [19]</b> 81/18 89/1 90/3 98/2 100/6 101/12 105/7 106/23 116/2 116/8 138/8 139/8 162/5 169/23 170/11 176/14 178/13 196/12 201/13</p> <p><b>wide [9]</b> 4/13 22/4 64/20 67/9 71/6 73/9 111/21 112/1 133/18</p> <p><b>widened [1]</b> 89/8</p> <p><b>wider [9]</b> 79/1 79/2 89/15 132/3 136/9 154/13 185/8 202/24 203/22</p> <p><b>will [34]</b> 6/19 13/19 26/3 30/15 38/21 44/21 47/5 51/10 52/2 52/4 54/13 55/22 65/22 70/9 70/10 80/5 93/2 100/1 102/1 102/17 124/12 128/22 130/12 138/15 138/16 139/3 143/11 151/22 152/5 191/4 191/18 191/18 202/16 202/18</p> <p><b>William [1]</b> 66/7</p> <p><b>willingness [1]</b> 129/11</p> <p><b>windows [2]</b> 200/8 200/17</p> <p><b>winter [7]</b> 19/4 33/6 73/3 86/23 86/24 87/6 158/1</p> <p><b>wished [1]</b> 121/6</p> <p><b>wishes [2]</b> 121/15 121/25</p> <p><b>within [29]</b> 3/9 11/25 13/16 19/17 20/18 26/3 26/9 28/3 33/21 35/17 36/15 38/15 51/3 59/3 60/24 64/8 97/3 116/21 122/4 129/13 131/23 131/24 144/19 147/11 148/16 171/22 174/22 174/25 178/1</p> <p><b>without [5]</b> 110/23 130/3 139/14 165/4 195/19</p> <p><b>witness [28]</b> 53/24 56/1 56/2 61/10 65/15 65/17 65/23 65/25 67/6 71/5 88/12 109/18 109/22 115/11 130/9 132/12 132/21 132/22 133/7 144/11 157/8 161/11 162/24 164/19 166/9 167/7 167/12 167/17</p> <p><b>witnessed [1]</b> 81/4</p>	<p><b>witnesses [2]</b> 1/7 109/17</p> <p><b>women [6]</b> 12/10 52/8 151/13 151/15 162/2 162/15</p> <p><b>won't [10]</b> 39/10 74/16 83/4 151/23 151/25 174/13 189/6 191/15 191/16 201/9</p> <p><b>wonder [1]</b> 57/1</p> <p><b>wondered [1]</b> 87/3</p> <p><b>wonderful [2]</b> 56/8 138/2</p> <p><b>wondering [2]</b> 7/6 191/11</p> <p><b>word [1]</b> 90/15</p> <p><b>words [3]</b> 75/5 96/10 108/14</p> <p><b>wore [1]</b> 107/10</p> <p><b>work [49]</b> 4/6 5/3 5/8 14/21 20/14 21/8 26/4 26/10 26/13 44/7 44/8 45/20 55/17 56/10 58/18 73/7 76/19 76/25 84/9 84/20 89/18 94/18 95/23 95/23 96/7 96/7 111/22 113/24 115/16 133/18 134/1 134/3 135/5 135/7 135/20 141/12 148/10 149/13 158/18 169/4 175/15 177/10 181/9 190/19 190/20 198/2 199/6 205/5 205/5</p> <p><b>worked [10]</b> 48/6 95/13 96/1 155/2 179/12 198/10 203/16 203/17 203/17 203/18</p> <p><b>worker [3]</b> 146/21 175/6 175/9</p> <p><b>workers [10]</b> 76/24 97/4 129/5 176/16 176/19 176/21 177/5 177/11 177/13 188/4</p> <p><b>workforce [18]</b> 27/14 33/20 35/4 35/8 35/9 50/12 50/16 53/11 53/16 89/14 89/15 89/25 102/22 135/12 141/2 141/3 159/7 166/5</p> <p><b>working [30]</b> 3/20 11/22 21/17 36/18 43/24 58/13 64/17 73/21 73/24 84/12 84/12 84/17 92/20 116/19 138/23 147/11 154/17 156/18 160/16 162/23 164/15 170/22 171/15 173/17 176/19 188/10 188/11 190/3 197/10 203/19</p>	<p><b>works [1]</b> 201/23</p> <p><b>world [1]</b> 154/25</p> <p><b>worried [3]</b> 98/16 195/12 195/20</p> <p><b>worry [1]</b> 151/8</p> <p><b>worrying [1]</b> 84/18</p> <p><b>worse [6]</b> 33/9 34/7 79/13 83/1 86/12 97/9</p> <p><b>worst [2]</b> 146/22 158/25</p> <p><b>worth [3]</b> 40/23 48/12 101/16</p> <p><b>worthwhile [1]</b> 205/14</p> <p><b>would [169]</b> 2/9 3/7 4/16 10/17 10/19 12/20 15/13 18/1 18/1 18/10 20/13 25/6 25/6 28/25 29/24 32/12 32/16 32/16 35/15 35/15 35/17 35/22 35/23 36/11 36/12 36/21 38/13 47/4 47/17 50/16 51/1 51/22 52/21 53/21 54/9 55/12 56/4 56/7 58/19 60/12 60/25 61/19 61/24 61/25 62/1 62/2 62/5 64/24 68/18 72/14 73/23 75/17 75/25 76/2 76/9 76/16 76/17 82/21 84/1 90/4 95/7 95/17 97/6 98/20 100/16 102/3 102/9 102/25 103/16 103/19 103/20 103/23 105/10 107/23 108/11 113/7 113/22 115/22 116/2 116/4 116/10 116/12 116/15 116/17 116/19 116/23 116/24 118/6 118/7 118/9 119/21 119/23 119/24 120/1 120/2 120/6 121/3 121/15 121/19 122/21 124/8 124/17 124/21 124/22 124/23 124/24 124/24 124/25 125/1 125/6 125/18 125/25 127/9 127/16 128/3 128/7 128/8 128/15 128/25 129/4 129/23 130/2 130/19 131/4 131/6 131/18 131/24 137/10 137/21 143/7 144/8 147/25 149/2 149/5 149/21 149/23 149/25 151/6 151/6 158/18 158/21 160/8 160/14 165/8 165/10 167/12 169/21 170/24 173/4 175/6 175/13 179/13</p>	<p>179/16 179/18 179/18 179/19 180/4 182/19 183/12 183/21 188/13 188/19 188/19 188/20 188/21 191/8 193/20 197/2 203/21</p> <p><b>wouldn't [11]</b> 32/17 52/24 61/21 61/23 61/25 63/4 85/2 85/5 113/22 130/1 130/2</p> <p><b>wraparound [1]</b> 5/7</p> <p><b>writing [1]</b> 164/8</p> <p><b>written [1]</b> 72/25</p> <p><b>wrong [7]</b> 54/9 69/25 82/14 101/18 106/8 137/10 147/25</p> <p><b>wrote [4]</b> 72/17 72/22 142/17 155/9</p> <p><b>Y</b></p> <p><b>yeah [57]</b> 6/13 9/22 12/25 14/4 18/11 22/2 25/8 25/18 26/16 26/19 35/13 36/11 38/10 41/7 41/10 43/4 43/20 44/4 69/20 72/16 75/10 76/2 76/2 76/20 77/5 80/7 81/21 82/9 83/16 83/25 84/3 84/11 86/4 86/14 86/14 90/14 90/16 93/4 94/4 95/10 96/17 98/1 100/9 102/6 103/19 105/1 105/9 112/9 118/3 129/2 140/6 155/15 170/3 170/14 195/6 197/5 200/5</p> <p><b>year [29]</b> 18/25 23/4 34/15 34/16 34/17 34/20 39/14 51/17 52/8 55/18 70/16 73/25 82/17 83/2 85/24 86/2 86/16 88/20 125/7 137/6 152/19 196/5 196/6 196/18 196/19 196/25 197/1 197/4 205/2</p> <p><b>years [14]</b> 34/17 34/18 51/25 66/16 67/22 70/14 102/17 113/18 125/9 134/14 136/11 141/4 141/12 166/13</p> <p><b>yes [113]</b> 2/8 2/13 3/4 6/25 13/2 13/3 15/6 15/15 22/18 22/24 23/1 23/8 24/17 25/14 28/14 30/24 38/5 39/4 39/9 39/9 40/11 41/9 43/2 44/9 44/18 51/16 52/19 52/25 53/2 53/23 54/3 57/6 65/25</p>	<p>66/7 66/12 67/24 72/21 73/5 75/7 79/20 79/22 81/8 81/8 82/3 83/8 83/12 83/23 85/2 85/25 86/18 87/11 88/13 95/13 97/19 101/25 105/25 110/19 111/11 111/20 112/23 113/2 120/23 121/9 123/10 124/21 125/14 127/11 128/17 132/19 139/12 141/23 142/1 142/10 143/10 143/18 144/22 145/4 146/3 146/5 146/8 148/3 149/2 149/7 155/20 156/1 156/1 156/1 156/20 158/7 158/17 159/17 160/5 160/6 160/10 160/18 166/21 166/25 168/12 168/19 171/1 176/12 177/14 179/11 179/25 181/5 182/21 184/24 187/20 192/17 193/12 198/7 199/11 204/14</p> <p><b>yet [3]</b> 91/18 131/8 190/10</p> <p><b>you [761]</b></p> <p><b>you'd [3]</b> 36/3 165/20 181/21</p> <p><b>you'll [8]</b> 14/12 17/3 30/3 36/7 41/7 71/10 85/21 152/23</p> <p><b>you're [24]</b> 38/24 55/25 57/4 61/5 66/5 67/7 76/4 96/25 104/25 109/5 116/3 125/4 132/18 134/22 134/23 134/24 139/14 139/16 139/17 154/3 156/15 204/6 204/9 205/16</p> <p><b>you've [40]</b> 1/23 2/5 4/13 9/6 10/13 24/20 40/6 47/19 48/9 50/24 55/15 55/24 56/16 61/11 65/9 65/14 96/25 97/7 105/14 107/23 108/25 109/1 109/22 110/20 131/3 132/15 136/23 137/15 153/13 156/21 159/12 162/25 163/18 166/14 172/9 181/21 184/1 199/8 203/15 205/17</p> <p><b>young [152]</b> 1/9 2/12 2/21 2/22 2/22 3/2 3/7 3/10 3/18 3/21 4/4 4/5 4/7 4/19 4/25 5/12 5/17 5/24 6/5 7/10 9/2 9/9 9/13 9/21 12/6 15/13 16/4 19/18 20/4</p>
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<p><b>Y</b></p> <p><b>young... [123]</b> 20/11  20/18 21/1 21/9 21/13  21/14 21/20 21/25  22/5 22/9 22/20 24/3  24/4 24/25 25/24 26/5  26/6 27/14 28/4 28/8  30/19 30/21 31/10  31/24 32/6 32/9 33/5  36/13 37/10 38/15  40/4 40/4 45/5 45/15  46/9 47/1 47/12 47/20  47/21 48/15 48/22  49/1 49/12 49/18  49/24 50/4 50/7 50/23  51/4 51/8 51/15 52/9  52/17 53/6 53/9 53/15  54/8 54/18 54/25 55/2  55/8 55/19 58/2 60/10  60/15 61/13 63/24  68/3 68/7 69/15 70/25  71/4 71/16 72/11  72/19 72/23 73/8 73/9  73/13 73/15 73/21  74/18 75/8 75/13  75/15 75/17 75/19  76/2 76/13 76/25  76/25 77/1 77/6 77/9  77/17 88/8 90/23  91/17 92/2 92/13 93/7  93/18 94/17 94/19  95/22 97/24 97/25  99/24 100/8 114/9  122/6 122/16 123/22  135/16 149/5 165/1  165/3 165/12 165/18  173/16 174/10 179/3  204/24</p> <p><b>your [184]</b> 1/15 1/20  2/25 4/16 5/24 6/9  6/14 6/19 9/12 16/16  22/13 23/2 23/22  24/23 26/12 29/11  32/3 33/2 34/24 37/2  37/8 37/18 39/12  41/11 44/20 44/23  46/18 48/20 49/16  49/17 51/1 52/14  54/23 55/25 61/10  66/6 66/13 66/23  67/18 67/25 68/20  69/6 70/22 71/2 71/19  72/10 73/24 76/4  76/18 77/3 79/24  82/12 84/4 90/7 91/21  92/17 92/18 94/15  96/10 97/20 99/5  99/20 101/12 101/19  103/9 103/18 106/7  106/7 106/17 110/20  110/21 110/25 111/4  111/9 112/7 112/8</p>	<p>112/10 112/17 112/18  112/20 112/22 113/13  114/9 114/15 115/11  116/5 116/25 117/3  117/22 118/1 118/18  119/3 119/24 120/14  121/12 122/7 123/3  123/5 123/7 123/25  124/18 125/12 126/8  127/1 128/2 128/14  130/7 130/9 131/3  133/3 133/21 143/19  144/11 145/25 147/21  147/22 151/1 153/13  153/16 155/22 156/23  157/8 159/14 160/11  161/11 161/21 161/22  162/13 162/13 163/16  164/19 164/21 166/19  167/21 168/6 168/16  168/20 168/23 169/3  169/13 169/13 169/14  169/15 169/17 169/25  170/16 170/17 170/20  170/25 172/20 177/6  177/16 179/6 179/9  179/22 180/23 180/24  180/25 181/18 184/3  184/7 185/19 186/24  187/23 189/1 189/3  189/22 190/22 191/11  192/24 194/9 194/16  195/13 196/2 197/25  198/1 199/16 199/17  199/23 200/2 201/6  201/7 201/9 204/10</p> <p><b>yourself [2]</b> 162/13  195/22</p> <p><b>youth [4]</b> 4/8 73/19  73/25 76/23</p> <p><b>youth/Secretary [1]</b>  73/25</p> <hr/> <p><b>Z</b></p> <p><b>zero [1]</b> 143/23  <b>zoom [1]</b> 186/21</p>			
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