**IN THE UK COVID-19 PUBLIC INQUIRY**

**BEFORE BARONESS HEATHER HALLETT**

**IN THE MATTER OF:**

**THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK**

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**Submissions on behalf of Covid-19 Bereaved Families for Justice and NI Covid -19 Bereaved Families for Justice for the Module 3 preliminary hearing on 28 February 2023**

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1. These submissions are provided on behalf of CBFFJ and NI CBFFJ in advance of the first Module 3 preliminary hearing on 28 February 2023. CBFFJ was established to campaign for this Public Inquiry: the families are committed to making it work. Submissions for a change of approach from the Inquiry are intended to assist the Inquiry's important work.

Rule 9 requests and disclosure

2. CBFFJ and NI CBFFJ note that CTI's note for the Module 3 preliminary hearing states that "Core Participants will not be provided with copies of the Rule 9 request made by the Inquiry in relation to Module 3" and that CPs will receive monthly updates from the Solicitor to the Inquiry. CBFFJ and NI CBFFJ further note that disclosure for Module 3 will begin this summer.

3. We remain concerned however that in the absence of disclosure of the Rule 9 requests themselves we are unable to assist the Inquiry with relevant lines of investigation to be pursued. We therefore renew our request for disclosure of the Rule 9 requests and rely on matters raised in previous written and submissions for the preliminary hearings in Module 1 and Module 2.

4. We renew our concerns raised in relation to the Inquiry's use of the disclosure platform which continues to impact our preparation and invite the Inquiry to revisit our concerns raised both with the Inquiry's team and in our submissions in Module 1 for the preliminary hearing on the 14th February 2023.

Rule 10

5. Certain fundamental aspects lay at the heart of any public Inquiry. The search to uncover the truth and learning lessons are often cited as the most important. We submit that of equal importance is the effective participation of those directly affected by the issues, the victims and the bereaved. Whilst the importance of expert evidence is not to be underestimated or undervalued, it is through the lived experiences of the victims and bereaved, that the Inquiry can glean vital evidence to address those fundamental aspects of its tasks. The ability and need for those directly affected to pose questions to witnesses through their own legal teams provides not only a different perspective and voices to an Inquiry, it provides a different dynamic and direction to the questioning, which often leads to further illumination and clarity in the answers elicited.

6. We note the observations and concessions made in respect of questioning of witnesses at following the hearing for Module 1. In relation to Module 3 we submit facilitating CP questioning ensures the effective participation of the bereaved and others. That is central to their confidence in the Inquiry, catharsis and some form of resolution. That in turn engenders wider public confidence in the Inquiry. Permitting CP questioning will also ensure a greater diversity of questioners. That is both important and beneficial in this Inquiry.

Parliamentary privilege

7. CTI's Note for this preliminary hearing has not mentioned parliamentary privilege. CBFFJ and NI CBFFJ have already made submissions on this issue, most recently in relation to Module 1. The group do not repeat those submissions here but maintain the submissions made both in writing and orally at the hearing on the 14th February 2023.

Every Story Matters

8. CBFFJ and NI CBFFJ reiterate concerns that they have raised within Modules 1 and 2 as to the lack of clarity about how the Listening Exercise is to work in practice. We invite the Inquiry to provide a definitive document setting out the process, in detail, including who is involved, how it will operate, and when. As raised previously, the families also need transparency on conflicts of interest in respect of those appointed/being considered for the delivery of the Listening Exercise (including the criteria the Inquiry is applying to such conflicts, if any), and how such conflicts are being considered. Without transparency on process and conflicts, whether real or perceived, families will be unable to make an informed choice on whether they intend to participate.

Race, inequality and discrimination

9. The preliminary paragraph of Module 3 Provisional Scope confirms that this module will "*examine healthcare-related inequalities*". The scope document mentions ethnic background twice, in paragraphs 7 and 10, both of which concern the impact of the

pandemic on healthcare staff. While CBFFJ consider this to be an important topic to cover, it is also important that the Inquiry looks at the ethnic background of NHS patients and their families who were impacted by the pandemic. The impact of health care related inequalities impacted disproportionately upon people within the population as a whole and it is vital that the Inquiry examines this rigorously.

10. In particular, the Inquiry should interrogate what was known by the WHO, and by the UK government, of the impact of Covid-19 on persons of various ethnic backgrounds, how this information communicated to NHS leaders, and how (and how rapidly) local NHS bodies used the information to protect communities most at risk.

11. We wish to revisit our previous submissions in relation to issues of race and discrimination, in writing and orally. We refer the Inquiry to our previous submissions prepared for the Module 1 hearing, at paragraph 14 of that document, with regards to this.

12. We return to this topic, cognisant and appreciative of the Inquiry's commitment to exploring the issues of race, discrimination and inequalities within this public Inquiry. It is however of vital importance to acknowledge the fact that the pandemic, whilst affecting all strata of society, regardless of race, socio economic class, gender, physical or mental vulnerability or disability, nonetheless impacted certain groups differently and disproportionately.

13. Moreover, these are issues which overarch all the modules and cannot and should not be investigated or examined in isolation from module to module.

14. The existence of different categories of people, some with protected characteristics by virtue of equality legislation, was neither novel or new at the time of the pandemic.

15. By way of example, the PSED. This is "not a duty to achieve a result" but a duty "to have due regard to the need" to achieve the goals to eliminate discrimination, advance equality of opportunity and foster good relations.. It is directed at ensuring that there is *"a culture of greater awareness of the existence and legal consequences of [in that case] disability*[1]". The duty must be exercised in "*substance, with rigour, and with an open mind*[2]*" and there must be "a proper and conscientious focus on the statutory criteria".*

16. Typically, public authorities discharge their "due regard" obligation under the PSED by the preparation of an equality impact assessment ("EIA") in relation to existing and proposed policies and practices. An EIA will include details of the characteristics of the groups that may be affected by any policy or practice and an assessment of the impact,

[1] *Pieretti v Enfield London Borough Council* [2011] PTSR 565, at §28
[2] *R (Brown) v Secretary of State for Work and Pensions (Equality and Human Rights Commission intervening*) [2009] PTSR 1506 at §92

both disadvantage and advantageous, on those groups. It will also weigh the impact on those groups, taking into account any mitigating measures as against the aims of any policy or practice[3]. This will then inform the public authority's decision on whether to adopt, or to retain, the policy or practice in question.

*Special protection afforded to vulnerable and minority groups*

17. In circumstances where a risk to life is posed to a vulnerable group, the case-law makes it clear that the State should take particular care to ensure that measures taken "correspond to [those persons'] special needs".

18. We have previously set out at paragraph 14 of the submissions for Module 1 dated January 2023; that racism and inequalities operate on a number of different levels, both structural and individual. We do not seek this Inquiry to undertake the task of investigating whether there is such a concept of structural racism exists, as clearly it does. This is not new concept; and in the context of this public Inquiry, structural racism has hitherto been recognised by institutions and organisations, such as the NHS. The issue of structural racism within the context of the health service, provisions of health care and access to health care, was very much a live one well before the pandemic. There was a recognition that this was an area which health providers had to address and recitify.

19. In the journal: *Occupational Medicine*, Volume 72, Issue 2, March 2022, Pages 65–66, Sheetal Chavda notes in the article: **Supporting BAME workers and occupational risk from Covid-19:**[4]

> *"In the early stages of the pandemic, it became evident that many of the healthcare workers who were dying were from ethnic minority backgrounds. This was confirmed by an analysis that was undertaken by senior clinicians within the National Health Service (NHS) on deaths in healthcare workers up to April 2020. They found that 71% of nurses/midwives and 94% of doctors/dentists who died were from 'Black, Asian and minority ethnic (BAME) background'. For reference, at the time of the analysis, 'BAME staff' constituted 20% of nursing/midwifery and 44% of doctors/dentists in the NHS workforce [1]. At that time, there was speculation that this may have been due to genetic factors or co-morbidities; however, further research into this has shown that there are likely to be wider issues contributing to these differences."*[5]

20. The article further notes:

[3] There are also allied monitoring and publication duties: Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, SI 2017/353.
[4] Available at < https://academic.oup.com/occmed/article/72/2/65/6374024 > last accessed 21 February 2021
[5] Ibid at 65

> ***"****In August 2020, Public Health England (PHE) published a report on their review of the data on disparities in the risks and outcomes of COVID-19 which found that death rates were higher in most ethnic minority groups compared to White British, with the highest mortality in Black males. Their analysis, however, did not take into account the effect of occupation, co-morbidities or obesity [3]. A previous ICNARC report published in May 2020 also found a higher proportion of Black and Asian patients with COVID-19 in the critically ill group that needed advanced respiratory support [4]."*

21. Sheetal Chavda concludes that whilst it may not be possible to know all the factors that have created the inequalities *" it is now imperative that there is a concerted effort to not only acknowledge these differences but also to implement recommendations that can bring about effective and lasting change."*

22. We reiterate the submissions made at paragraph 18 of the Module 1 submissions, in particular:

> *"As well as housing, the UK's immigration policies[6], access to health[7] and criminal justice system[8] are all blighted by complaints of structural racism. These are all inequalities which were well documented and known prior to the pandemic. It then begs the question, were they acted upon? If so why not?"*

23. In relation to Module 3, as inequalties in access to health care were well documented and known prior to the pandemic. We ask the following further questions:

    1. The health service as an employer has a very high proportion of staff from black and brown ethnic groups within the population. Why was this prior knowledge not factored into, or form a significant part of the planning, response and implementation and provision of services in the wake of the pandemic?

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[6] https://www.theguardian.com/commentisfree/2022/may/30/britain-immigration-system-racist-laws The truth is out: Britain's immigration system is racist, and always has been. Now let's fix it.

[7] https://blogs.bmj.com/bmj/2020/03/05/women-from-ethnic-minorities-face-endemic-structural-racism-when-seeking-and-accessing-healthcare/ "Black women are five times more likely to die during childbirth, and Asian women are twice as likely to die during childbirth compared with white women in the UK. These are the findings of the "*Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK"* reports (MBRRACE) in 2018 and 2019

[8] https://news.un.org/en/story/2023/01/1132912

Racism in the United Kingdom is "structural, institutional and systemic", independent UN human rights experts said on Friday, warning that people of African descent in the country continue to encounter discrimination and erosion of their fundamental rights.

"We have **serious concerns about impunity and the failure to address racial disparities in the criminal justice system**, deaths in police custody, 'joint enterprise' convictions, and the dehumanising nature", of the so-called 'stop and search' policing strategy, the UN Working Group of Experts on People of African Descent said in a statement at the end of an official visit to the UK.

2. To what extent was the core decision-making and leadership within healthcare systems during the pandemic affected by structural racism and discrimination?

3. To what extent was the decision-making about the nature of healthcare to be provided for patients with Covid-19 affected by structural racism and discrimination?

Experts

24. Further to the instructions of experts on the issues of race and discrimination; given the well documented disproportionate impact of the covid 19 pandemic on black and brown people across the UK, we submit that the questions positied above, can only be appropriately and adequately addressed by an expert in structural racism.

25. As previously stated we welcome the Inquiry's instruction of Professors Sir Michael Marmot and Claire Bambra who have been instructed to provide reports for Module 1 on the existence of health inequalities prior to the pandemic in public health structures in the UK and planning for a pandemic. We intend no slight to the integrity or relevance of these experts, but note that neither Professors have expertise in structural discrimination and structural racism and so their investigation and reports on health inequalities will be devoid of such analysis. That would be a significant and regrettable omission. We consider such omission to fall short of the Inquiry's stated objective (above) and invite the Inquiry to include the investigation into structural racism and discrimination in Module 3 for the reasons set out above. Moreover, as argued for the reasons below at paras 28029, an expert on the complex health and social care system in Northern Ireland is required. Respectfully, neither Professors seem to have this expertise.

26. We repeat our submission at paragraph 15 of the Module 1 submissions in relation to the providing the letters of instruction to the CPs. A letter of instruction (LOI) is an important document and fundamental to ensuring that the subsequent report is relevant and properly addresses the matters under investigation. The LOI sets out the basis upon which the expert is being instructed. Additionally and importantly, the LOI should clearly state the areas, topics, and questions upon which that their expert opinion is sought. These two functions are essential. We submit that it is both extremely helpful and good practice for other parties to have sight of and often imput into the LOI, to ensure it is comprehensive and addressing all relevant matters. These submissions will be expanded upon in oral submissions at the hearing on 28th February 2023.

Scope

27. The Scope of Module 3 is drawn from three documents: the Inquiry's Terms of Reference, the Module 3 Provisional Scope, and paragraph 33 of CTI's note for the preliminary hearing dated 14 February 2023.

*Devolved nations*

28. Health is a devolved matter. It would be helpful if the Inquiry could explain how it will conduct Module 3 in relation to the four nations. In particular, when it comes to Northern Ireland, it is unclear from CTI's note and the provisional scope *how* the impact on the healthcare system in Northern Ireland will be addressed by the Inquiry. Due to the complexities of the Northern Ireland system and its unique combined health and social care model (which includes cross-border healthcare service), CBFFJ NI believes that it is essential that an expert in Northern Irish health and social care be appointed so that the Inquiry can understand fully the impact of the pandemic on the health care system.

29. We note at paragraph 34 of the CTI's note that the Inquiry's terms of reference do not include 'the state of healthcare systems in the United Kingdom prior to the pandemic, save where necessary to understand how the pandemic impacted on healthcare systems.' However, in order to understand the impact of the pandemic on the healthcare system in Northern Ireland, the Inquiry must first understand the dire prevailing healthcare system *before* the pandemic. The healthcare system in Northern Ireland was described recently by an expert witness in a recent judicial review of the waiting lists[9] as "catastrophic", with "appalling performance" and it being in a state of "functional collapse". The collapse has manifested in the length of waiting lists in Northern Ireland being far worse than the UK average. For example, as of June 2021 (over one year into the pandemic), the waiting list in England was equivalent to just 9% of the population, whereas those waiting in Northern Ireland – 57% – had been waiting for over a year.[10] The situation in Northern Ireland has deteriorated even further. For these reasons, CBFFJ NI believes that in order to properly consider the impact of the pandemic on healthcare in NI, the Inquiry must first understand the prior state of the healthcare system in Northern Ireland.

*Interaction with social care*

30. The Inquiry's website lists "*the care sector*" under future modules. CBFFJ and CBFFJ NI note what is said by CTI at paragraph 33(d) of the note to the Module 3 preliminary hearing. It is vital that Module 3 covers all decisions taken in respect of NHS patients while they remained in NHS facilities. This includes whether they were provided with tests before they were discharged, whether into the community or into a care home.

31. CBFFJ and CBFFJ NI encourage the Chair to ensure that the care sector is not brought into Module 3 by stealth, and invite her to announce that Module 4 will focus on the care sector for the following reasons:

[9] *Re Wilson* [2023] NIKB 2, [26]

[10] Dayan and Heenan, 'Seven points of action to help address Northern Ireland's waiting list woes', Nuffiled Trust, 4 June 2021, available at < https://www.nuffieldtrust.org.uk/news-item/seven-points-of-action-which-would-help-address-northern-ireland-s-waiting-list-mess-once-and-for-all > last accessed on 20 February 2023.

a. A significant number of people died in social care settings during the pandemic. CBFFJ and CBFFJ NI consider the care home situation to be a major national scandal that requires the Inquiry's urgent attention;

b. There was (and continues to be) a clear interplay between healthcare provision and social care provision. For example, people were discharged from the NHS estate into care homes to "protect the NHS"; in many cases, GPs refused to visit care homes, and care home residents requiring hospital care were denied it;

c. Families and friends of people who live in care homes or supported living placements continue to face difficulties visiting their loved ones due to restrictive visiting rules. The Inquiry's recommendations are likely to have immediate benefit; and

d. In England, one central government ministry - the Department of Health and Social Care - is responsible for both healthcare and social care. It makes sense for the social care module to follow directly from Module 3 on healthcare.

e. The situation in Northern Ireland is different. Although the devolved Department of Health in Northern Ireland has overall responsibility for health and social care services, both services are provided by the 5 Health and Social Care Trusts. Another statutory body, the Health and Social Care Board, was responsible for the commissioning of both services until it was subsumed into the Department on 31 March 2022. This differs from the bifurcated position in the rest of the United Kingdom where the NHS provides health services and local councils provide social services. The complex relationship between the Department, the Trusts and the Board in Northern Ireland means that the Inquiry will have to consider how this structure can be examined carefully. Indeed, because of the combined service in Northern Ireland, it may be that it is not possible to consider healthcare in complete isolation in Module 3 and rather it is necessary to consider elements of social care in Module 3 and elements of health care in a future social care module. Perhaps due to the combined services, Northern Ireland had a better response in some respects from which lessons could be learned for the entire United Kingdom. Again, for these reasons, CBFFJ and CBFFJ NI believe it is essential that an expert in health and social care in Northern Ireland be appointed to assist the Inquiry with its understanding of the unique system in operation in Northern Ireland and to avoid important elements of a combined health and social care system falling between the cracks caused by isolated modules.

*Therapeutics*

32. The Inquiry's website states that "Vaccines, therapeutics and anti-viral treatment" will be dealt with in a future module. CTI's note for the preliminary hearing states at paragraph 33(b) that Module 3 will include "How the treatments available to those suffering from

Covid-19 developed and changed over the course of the pandemic". It is unclear whether therapeutics are within scope of Module 3 or not.

*Discharge from NHS settings*

33. The final sentence of paragraph 5 of Module 3 Provisional Scope reads "*the discharge of patients from hospital*". CBFFJ consider this should be a major theme. During the pandemic, the NHS rushed to discharge many thousands of people from the NHS estate to care homes, to supported living placements and to their own homes.

34. Many were discharged without being tested, so that they were discharged when they unknowingly had Covid. Many CBFFJ and NI CBFFJ members feel that they were denied information about discharge options for their loved ones, and many people were discharged with unsafe packages of care. Many people carried Covid asymptomatically to their discharge destination including care homes where they mixed with other older or vulnerable people and their staff. Given that discharge decisions were made by the NHS, the Inquiry is asked to deal with this matter in Module 3, rather than in the future social care module.

*Testing*

35. The Inquiry's Terms of Reference at paragraph 1(b)(iv) mentions "*workforce testing*" in the context of management of the pandemic in hospitals. Module 3 Provisional Scope does not mention testing. In our submission, the Inquiry should investigate:

36.

a. the timeline for tests being available in healthcare settings for healthcare staff and patients;

b. whether sufficient numbers of tests were made available to the NHS;

c. any regional disparities about the availability of tests;

d. how rationing decisions were made;

e. the false negative rates of tests (whether lateral flow or PCR), whether different manufacturers produced tests with better reliability than others; how test reliability fed into contracting decisions;

f. the funding of, and location of, laboratories that could produce PCR test results;

g. the speed with which test results were produced and whether delay impacted on clinical outcomes;

h. the adequacy of guidance on testing, including whether tests were limited to those with a temperature or a cough and whether the guidance kept up with what was known about the virus and its effects; and

i. whether testing patients in the NHS was prioritised over testing older or vulnerable residents in social care settings.

37. It is understood that testing availability for staff and residents/clients in the social care sector will not be covered in Module 3, but will be within scope of the social care module.

*Inspections and monitoring*

38. The Inquiry's Terms of Reference includes at paragraph 1(b)(iv) "*changes to inspections*" of hospitals. However, Module 3 Provisional Scope does not mention inspectorates. In England for example, the Care Quality Commission stopped its inspections of hospitals in March 2020. This resulted in the removal of a key patient safety safeguard. The Inquiry should interrogate the reasons why inspectorates stopped visiting hospitals, whether alternative arrangements could have been made, whether inspectorate bodies breached their statutory duties and whether patients were put at risk.

39. In the absence of inspectors on the ground, the Inquiry should consider what alternative arrangements were put in place and whether any interim provisioneffectively monitored hospitals' compliance with guidelines, shared emerging best practice on infection prevention and control, and made rapid recommendations for hospitals with high to numbers of hospital-acquired infections to take corrective actions.

40. The Inquiry should establish which organisation was responsible in each nation for collating data on hospital Covid cases (including hospital acquired Covid), what actions those organisations took to share information and to require infection prevention and control teams locally to take appropriate action.

41. A potentially complicating factor was that local authorities (not the NHS) have responsibilities for public health locally. The Inquiry should look at the collaborative working arrangements of the various responsible bodies.

*Triage / NHS 111*

42. CBFFJ is concerned that many people were triaged away from NHS services and as a result were denied life-saving treatment and care. The Inquiry should examine triage systems, tools and algorithms within NHS 111, Ambulance Trusts, primary care, and hospitals. In particular, there is a concern that disabled people and older people were triaged away from services when it was known they were among the most vulnerable to a severe outcome.

*Maternity services*

43. The Inquiry's Terms of Reference at paragraph 1(b)(vii) includes "*antenatal and postnatal care*". Maternity services are missing from Module 3 Provisional Scope. Issues here include the availability of testing in maternity settings, the health and wellbeing on pregnant women, the impact on women and babies where women tested positive for Covid and the prohibition of birth partners.

*Ventilation*

44. Paragraph 8 of Module 3 Provisional Scope covers preventing the spread of Covid-19 within healthcare settings. CBFFJ and NI CBFFJ would like to flag at this early stage that this should include ventilation. It appears that SAGE were told about the importance of ventilation in March 2020, but hospital managers made no changes to ventilation systems.

*Patients vulnerable to a severe outcome*

45. Paragraph 11 of Module 3 Provisional Scope sets out "*Shielding and the impact on the clinically vulnerable (including those referred to as 'clinically extremely vulnerable')*". CBFFJ consider that the Inquiry should use person-first language and avoid phrases such as "*the clinically vulnerable*", "*the elderly*" or "*the disabled*".

46. CBFFJ further considers that paragraph 11 of the Provisional Scope should be expanded to consider healthcare provision of people who had clinical vulnerabilities, such as those who were inpatients in hospitals during the pandemic for other medical reasons and then caught Covid-19 in hospital. This should include looking at how central government cascaded information about vulnerability characteristics (e.g. patients receiving chemotherapy), and the actions taken by hospitals to protect those patients from acquiring Covid-19.

47. The Inquiry is urged to look at excess deaths caused by the pandemic. This would include the increased number of people dying at home as a result of deciding not to seek medical assistance, and increased deaths due to a delayed cancer diagnosis.

*Mental health*

48. Mental health is mentioned in paragraph 1(a)(x) of the Inquiry's Terms of Reference but is missing from Module 3 Provisional Scope. The scope of Module 3 should look at the adequacy and effectiveness of NHS mental health services to people affected by the pandemic, to include:

    a. the availability of community mental health care, including the reduction of domiciliary visits by community psychiatric nurses;

b. the effectiveness of telephone and digital interfaces with patients, and whether there were cohorts of people in the community who did not fare well with these methods, e.g. older people, autistic people, people with a learning disability;

c. the availability of inpatient mental health care, including children and adolescent services;

d. infection prevention and control in psychiatric units; and

e. bereavement counselling for adults and for children who lost loved ones to Covid.

*Registering and investigating deaths*

49. CBFFJ and NI CBFFJ urge the Inquiry to look at guidance issued by medical bodies such as the CQC and GMC on death certification and whether such guidance resulted in accurate recording on death certificates.

50. In 2020 the Chief Coroner published "Guidance No 34: Chief Coroner's Guidance for coroners on Covid-19".[11] This document stated that Covid-19 was a naturally occurring disease and therefore was capable of being a natural cause of death. As a result, thousands of families of people who died of Covid-19 (including those who died in hospitals) were denied an inquest into how their loved one came by their death. In many instances, Coroners told bereaved families that there was no need for a coronial investigation into how their loved one came by their death because the future national Inquiry would investigate the political and other decisions that may have caused or contributed to the individual's death. In relation to a potential future national Inquiry, the Chief Coroner stated in 2020 that in any case a Coroner "*may choose to suspend the investigation until it becomes clear how such enquiries can best be pursued*". The Inquiry will also have to consider separately the guidance given by the Coroners in Northern Ireland and Scotland. CBFFJ and CBFFJ NI ask that the Inquiry investigates the impact on bereaved families of being denied inquests into how their loved ones died.

51. Many CBFFJ and CBFFJ NI members whose loved ones died of Covid-19 in NHS facilities have found it difficult to obtain information about how their loved one died. Others have faced obfuscation and lies by the NHS in seeking the truth. They would invite the Inquiry to hear from them about their experiences including about apparent breaches of the duty of candour.

<u>Commemoration</u>

52. We welcome the Inquiry's continued work around the commemorations. Our clients remain committed to assisting with appropriate arrangements for commemorations. We

[11] Available at < https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-34-covid-19/ > last accessed on 21 February 2023

repeat our written and oral submissions made to the Module 1 preliminary hearing on the 14th Feburary 2023.

21 February 2023

Pete Weatherby KC
Allison Munroe KC
Anna Morris KC
Thalia Maragh
Oliver Lewis
Kate Stone
Jesse Nicholls
Mira Hammad
Ciara Bartlam
Counsel for CBFFJ

Ronan Lavery KC
Brenda Campbell KC
Conan Fegan
Malachy McGowan
Marieclaire McDermott
Counsel for NI CBFFJ

Elkan Abrahamson
Nicola Brook
Broudie Jackson Canter Solicitors
Solicitors for CBFFJ

Conal McGarrity
Enda McGarrity
PA Duffy Solicitors
Solicitors for NI CBFFJ