Agenda – Public Accounts and Public Administration Committee

Meeting Venue:	For further information contact:
Hybrid – Committee Room 5 Tŷ Hywel	**Fay Bowen**
and video conference via Zoom	Committee Clerk
Meeting date: 10 December 2025	0300 200 6565
Meeting time: 09.15	SeneddPAPA@senedd.wales

Private pre-meeting (09.00 – 09.15)

Public meeting (09.15 – 12.00)

1 Introduction, apologies, substitutions and declarations of interest

(09.15)

2 COVID-19: evidence session with the Welsh Ambulance Services University NHS Trust and the Fire and Rescue Services

(09.15 – 10.30) (Pages 1 – 28)

Lee Brooks, Executive Director of Operations – Welsh Ambulance Services University NHS Trust

Andy Swinburn, Executive Director of Paramedicine – Welsh Ambulance Services University NHS Trust

Assistant Chief Fire Officer Dean Loader, Director of Service Delivery – South Wales Fire and Rescue Service

Assistant Chief Fire Officer Craig Flannery – Mid and West Wales Fire and Rescue Service

Research brief

Written evidence from the Welsh Ambulance Services University NHS Trust

Break (10.30 – 10.35)

3 COVID-19: evidence session with the Covid Bereaved Families for Justice Cymru

(10.35 - 12.00) (Pages 29 - 337)

Anna-Louise Marsh-Rees

Sam Smith-Higgins

Written Statement

Annex 1

Annex 2

Annex 3

4 Motion under Standing Order 17.42 (ix) to resolve to exclude the public from the remainder of this meeting

(12.00)

Private meeting (12.00 - 12.30)

5 COVID-19: consideration of evidence

(12.00 - 12.10)

6 Forward work programme

(12.10 - 12.25) (Pages 338 - 350)

Forward work programme

7 Private paper to note

(12.25 - 12.30)

7.1 Letter from Dean Medcraft, Finance Director, Corporate Services and Inspectorates Group (CSI) - Welsh Government to the Chair regarding the Welsh Government Annual Report and Accounts 2024-25

(Pages 351 - 352)

Agenda Item 2

Document is Restricted

BEFORE THE SENEDD PUBLIC ACCOUNTS AND PUBLIC ADMINISTRATION COMMITTEE

COVID-19 EVIDENCE SESSION
10 DECEMBER 2025

WRITTEN SUBMISSIONS ON BEHALF OF
THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

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1. Introduction

1.1. The Welsh Ambulance Services University NHS Trust ("WAST or "the Trust") is grateful for the invitation from the Senedd Public Accounts and Public Administration Committee ("the Committee") to provide evidence to its members on 10 December 2025.

1.2. The Trust understands that the Committee's work will focus on the Welsh Government's current preparedness, response structures, and progress since the Covid-19 Pandemic to address the gaps identified by the Covid-19 Special Purpose Committee (dissolved on 08 October 2025). This includes its response to the UK Covid Inquiry Module 1 report, implementation of the Module 1 recommendations, and the Welsh Government's role in Exercise Pegasus.

1.3. The session on 10 December 2025 is expected to examine any gaps in relation to Module 1 of the UK Covid-19 Inquiry and consider the Welsh Government's Response to the Module 1 Report. Mr Lee Brooks, Executive Director of Operations and Mr Andy Swinburn, Executive Director of Paramedicine, at WAST, will attend in person to provide oral evidence to the Committee on behalf of the Trust.

1.4. The Committee has indicated that it would be grateful to receive written submissions in advance of the session on 10 December 2025 to inform the briefing for Members. These written submissions are being provided to the Committee with that purpose in mind.

1.5. Whilst the recommendations set out in the Module 1 report are of the utmost importance and relevance to WAST, they were ultimately directed at the UK and devolved governments, rather than individual organisations. Therefore, whilst WAST has

had the Module 1 recommendations in mind in its organisational planning, the implementation of changes should be centrally led to ensure consistency of approach across Wales wherever possible. WAST acknowledges that significant work has already been undertaken by Welsh Government in this regard and highlights the Wales Resilience Framework report and the supporting Delivery Plan, published by Welsh Government in May 2025.

1.6. WAST has considered the Module 1 report and the recommendations, which were structured around eight core principles, through its internal governance structures. The Pandemic Governance Group and a Task & Finish Group were both established to respond to the UK Covid-19 Inquiry, to review reports issued by Rt Hon the Baroness Hallett DBE (Chair of the UK Covid-19 Inquiry) and recommendations contained within these, to consider the Welsh Government's response, and to identify any necessary actions or implications for the Trust.

2. Overview

UK COVID-19 Inquiry

2.1. Understandably, given the scope of Module 1, WAST was not a Core Participant for the purposes of Module 1 of the Covid-19 Inquiry, nor was WAST asked to provide witness evidence for this module.

2.2. The Trust has taken note of the Module 1 UK Covid-19 Inquiry report published by the Rt Hon the Baroness Hallett DBE in July 2024. At section 3 of these submissions the Trust will set out its interpretation of the Module 1 findings; however, as noted above, these recommendations were ultimately directed at the UK and devolved governments.

2.3. WAST provided documentation, including a witness statement from its Chief Executive Officer (CEO) at the time, for Module 2B of the Inquiry. The Committee will be aware that the scope for Module 2B was to consider and make recommendations about the Welsh Government's core political and administrative decision making in relation to the Covid-19 pandemic between early January 2020 and May 2022. The Module 2 report

(including Modules 2A, 2B, & 2C) was published on 20 November 2025 and is being considered within the Trust's governance structures as outlined above.

2.4. WAST was a Core Participant for Module 3 and provided the Inquiry with documentation, as well as a witness statement from its CEO at the time. The Committee will be aware that the scope for Module 3 was to consider the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland, and Northern Ireland. The Trust understands that the Module 3 report will be published in Spring 2026.

2.5. The Trust was not called to give oral evidence to the Covid-19 Inquiry for any of the Modules to date.

Wales Covid-19 Inquiry Special Purpose Committee

2.6. WAST notes the content of the Special Purpose Committee's report, published in March 2025, on the gaps identified in the preparedness and response of the Welsh Government and other Welsh Public bodies during the Covid-19 pandemic.

2.7. WAST will address its involvement in this process in more detail at section 4.

2.8. The Committee has asked for information as to WAST's role in civil contingency structures and as such will endeavour to explain the position in this paragraph. WAST is a Category 1 responder under the Civil Contingencies Act 2004 and is subject to statutory duties focused on emergency preparedness, resilience and response. These duties include risk assessment, emergency planning, business continuity management, communication and cooperation with other agencies. As a national ambulance Trust, WAST is represented on civil contingency structures across Wales, including planning and response structures at appropriate levels of seniority (strategic, tactical and operational). This includes representation at the Wales Resilience Forum and its subgroup and at Emergency Planning Advisory Group (EPAG) and various subgroups; the mass casualty and, pre-hospital group, which WAST chairs. EPAG, which is currently in transition, reports into the NHS Wales Executive Civil Contingencies Leads Group on which WAST's Executive Director of Operations sits. WAST is also represented on the Systems Resilience Planning and Response Group, a key forum for horizon scanning

future threats and risks such as respiratory illness during the winter period. These structures are complemented by national ambulance structures through Association of Ambulance Chief Executives (AACE) and blue light collaboration through the Joint Emergency Services Group (JESG).

2.9. The Committee has requested information regarding WAST's contribution to whole systems resilience, with a focus on Covid specific aspects of this role and will endeavour to explain the position in this paragraph. Through these structures, which span both blue light and health systems, WAST is ideally placed and actively contributes to whole system resilience through partner collaboration, joint planning and regular training and exercising. WAST has had recent involvement in Exercise Pegasus – a tier 1 national exercise led by the UK Department of Health and Social Care (DHSC), aimed at rigorously assessing the UK's preparedness, capabilities and response strategies in the context of a pandemic arising from a novel infectious disease. WAST has actively participated in the three key dates throughout September, October and November 2025 by fielding strategic and tactical commanders across the four Local Resilience Forum (LRF) areas. WAST will contribute to any national debriefing, following our own internal debrief, which will support the review of our Pandemic Plan where necessary. All three waves of the Covid 19 pandemic were internally debriefed alongside a wholescale pandemic debrief undertaken by WAST once the UK Government officially declared the pandemic over. All debrief actions were assessed and actioned accordingly, including the most recent ones which included investment in vehicle based respiratory protective equipment (RPE) and business continuity software.

3. Module 1 UK Covid Inquiry report and Welsh Government Response

3.1. The UK Covid Inquiry Module 1 report and the Welsh Government report have both been carefully considered by WAST through its internal governance structures described in paragraph 1.6 and by the Trust's Executive Leadership Team (ELT).

3.2. Furthermore, as a member of the Welsh NHS Confederation, WAST has formally responded to each of the ten recommendations contained within the UK Covid Inquiry

Module 1 report, by way of document dated 3 January 2025. A copy of this document is provided with these submissions for reference.

3.3. This document responds to the Module 1 Report recommendations as follows:

- **Response 1** – Addressing recommendations **1 and 2** of the M1 UK report.
- **Response 2** – Addressing recommendation **3** of the M1 UK report.
- **Response 3** – Addressing recommendation **4** of the M1 UK report.
- **Response 4** – Addressing recommendation **5** of the M1 UK report.
- **Response 5** – Addressing recommendations **6 and 7** of the M1 UK report.
- **Response 6** – Addressing recommendation **9** of the M1 UK report.
- **Response 7** – Addressing recommendation **8** of the M1 UK report.
- **Response 8** – Addressing recommendation **10** of the M1 UK report.

3.4. The Trust makes the following additional observations:

3.4.1 WAST welcomes a simplified structure for whole system civil emergency preparedness and resilience. There are currently four LRFs in Wales, and a significant number of sub committees. WAST is a member of several of these sub-committees which is a significant commitment of WAST's resources. A simplified structure would minimise the risk of inconsistency in approach across these four areas.

3.4.2 WAST agrees with a revised approach to risk assessment. The publication of the UK National Risk Register (2025) and Wales Risk Register (2024) has been of assistance to the Trust in undertaking an assessment of its own preparedness aligned to key risks that impact on ambulance services and emergency response.

3.4.3 WAST notes that there remains a need for development in pan Wales organisational learning (for example following multi-agency events) and looks forward to future developments in this area.

3.5. Further to the publication of the UK Module 1 Report and the Welsh Government response to it, WAST has discussed each of the recommendations made in the report internally and has considered where changes can be made. The key point is that the changes highlighted in the report must be centrally led. WAST notes that the Wales Resilience Framework report and Delivery Plan (May 2025) set out a road map for the implementation of many of these recommendations.

4. Special Committee Report

4.1. WAST was involved in the consultation process for the preparation of the Special Purpose Committee report as set out below.

4.1.1. The Trust was invited to attend the stakeholder engagement event on 2 December 2024.

4.1.2. The following observation was made by WAST at that stakeholder event in relation to changes to resilience structures and which is acknowledged in the Special Purpose Committee's March 2025 report:
"*From an Emergency Preparedness Resilience and Response (EPRR) point of view, knowing what this team will be responsible for and how it will influence emergency planning within Wales is critical to organisational and Local Resilience Forum (LRF) emergency planning.*"

4.1.3. WAST notes and highlights the involvement of the Welsh NHS Confederation in the Special Purpose Committee's consultation process.

4.1.4. The Welsh NHS Confederation represents the seven Local Health Boards, three NHS Trusts (Velindre University NHS Trust, Welsh Ambulance Services University NHS Trust, and Public Health Wales NHS Trust), and two Special

Health Authorities (Digital Health and Care Wales and Health Education and Improvement Wales).

4.1.5. The Welsh NHS Confederation, of which WAST is a member, provided its response to the Special Purpose Committee's consultation process by way of document dated 3 January 2025 (referred to above).

4.1.6. WAST provided its own consultation response to the Special Purpose Committee on 17 January 2025 identifying 3 gaps that it considered the Special Purpose Committee should further evidence. Our response, submitted using the online form and addressing the set topics (underlined below) was as follows:

4.1.7. National Command Versus Regional Coordination

"There does not appear to be specific mention about how national organisations, providing services on a national scale, are split between the local resilience geography. This is incredibly difficult to effectively service, and so national command and control versus regional coordination is a point to test, as is the ability for a national organisation to service multiple regional structures when all are stood up at once".

4.1.8 Does the Module 1 Report Address the Actions Needed to Improve Wales's Preparedness?

"An area that has not been mentioned within the report but was discussed during the Pandemic Learning Workshop, is the need for the reviewed Pan Wales Plan to be shared and the need for this plan to reflect the realistic pressures that a Pan Wales response puts on to organisations whilst balancing the need for Wales to be part of the UK information sharing process and ensuring that there is a UK-wide joined up approach to an emergency that affects the whole of the UK".

4.1.9 Are Recommendations Realistic and Achievable Within the Timeframe?

"The Module 1 report is not clear where the Red Teams will be based or how many there will be. From an Emergency Preparedness Resilience and Response (EPRR) point of view, knowing what this team will be responsible for and how it will influence emergency planning within Wales is critical to organisational and Local Resilience Forum (LRF) emergency planning".

4.2. The Trust supports the findings of the Special Purpose Committee Report. Firstly, WAST considers that accountability for the implementation of each recommendation (with timescales provided) should be made clear to organisations in Wales to ensure consistency and clarity. This will assist in managing resources and will minimise the risk of duplication/waste of resource at organisational levels. In simple terms, who is responsible for what, and what are the timescales. WAST acknowledges the recent Wales Resilience Framework report (May 2025) published by the Welsh Government that has gone some way to dealing with this. Secondly, WAST agrees that there should be a further review of the effectiveness of the four LRFs. Thirdly, it is agreed that there is a need to address gaps in data collection and sharing across Wales and the UK. Fourthly, WAST agrees that local knowledge and expertise in preparedness and resilience planning is important. WAST observes a complicating factor arising from this is how to simplify structures whilst retaining local expertise where practicable. Finally, WAST would agree with the consultation findings that fulfilling expectations within existing resources is challenging.

5. WAST's current preparedness and plans

5.1 WAST makes the following comment in relation to its current preparedness. The Trust has statutory responsibilities set out in the Civil Contingencies Act. These include planning and preparation for incidents which impact our ability to undertake our core functions. Our assessment of risk, commitment to organisational learning and servicing of resilience structures across Wales, demonstrate our ongoing commitment to meet these requirements in a diligent and, where possible, proactive manner. Further details are provided below.

5.2 The Trust is involved in several data sharing and interoperability activities across the NHS in Wales and has recently signed the all-Wales Joint Controller Agreement which

supports the ambition of Welsh Government and all NHS Wales organisations to share data in future, specifically via Digital Health Care Wales (DHCW). The agreement has been developed as part of the National Data Resource programme that we mentioned, being run by DHCW.

5.3 The signing of this Joint Controller Agreement is a clear indication of our collaboration and strategic intention and is a fundamental element to ensure compliant sharing of our patients' sensitive health data in future, but there are still other governance arrangements which are required nationally to address Data Protection and Confidentiality laws, before we can share such data at scale.

5.4 As part of the National Data Resource programme, run by DHCW, the Trust is supporting national information governance, data protection and privacy work to enable the sharing of data across Welsh NHS Trusts and Health Boards in future. Data is regularly shared in relation to 999 with our Commissioners, DHCW, Public Health Wales (PHW) and Health Boards for the purposes of understanding Urgent and Emergency Care demand and operations. This includes sharing intelligence to support system performance (i.e. handover time at hospital data) and seasonal intelligence (i.e. conveyed fallers and those with breathing difficulties) with Welsh Government on a weekly basis through Winter.

5.5 The Committee has asked how WAST currently ensures its preparedness plans reflect Welsh Government commitments. Following the publication of the UK National Risk Register (2025) and Wales Risk Register (2024), WAST has undertaken an assessment of our own preparedness for the key risks which may impact on ambulance services and emergency response. This includes the identification of localised threats, and vulnerabilities relevant to the people of Wales. This exercise has assessed risk such as terrorism, cyber threats, state threats, weather related risk, critical national infrastructure failure, and Wales specific risk such as hazardous materials in the A55 tunnels, spoil tip landslides and Britannia bridge closures. In undertaking this assessment, WAST has reviewed our own existing documents pertinent to these risks, our capability training and exercising and has devised an internal preparedness score

which will inform our future work plans. A further, more detailed piece of work will follow in 2026/27.

5.6 Post-incident debriefing processes support the Trust in our organisational learning, with participation in multi-agency debriefs with the Powys train crash being a positive recent example of this. In October 2024, a passenger train heading westwards from Shrewsbury to Aberystwyth, collided head-on with another train travelling in the opposite direction on a section of single line near Talerddig, Powys. Fifteen people were injured in the crash, and sadly one individual subsequently died. Internally within WAST, lessons identified through incident debrief processes are recorded on our Organisational Learning Log. This is reviewed by our Senior Operations Team and assured by our Senior Leadership Team on a regular basis, with recommendations which span broader than WAST fed into Joint Organisational Learning (JOL) via the Resilience Direct platform. Single statutory agencies such as WAST retain responsibility for their own organisational learning, with LRFs as non-statutory bodies retaining oversight; however, this does not include accountability for any lessons identified. Subsequently WAST understands that there is no mechanism pan Wales to monitor and assure implementation of multi-agency organisational learning. If such a mechanism is in place it may be the case that more detailed, comprehensive communication in relation to its existence is required.

5.7 In changing the way that WAST responds to emergency calls across Wales, the organisation is demonstrating a continued focus on quality of care and patient outcomes, and not solely on response times. These changes are in response to a new Ambulance Performance Framework announced by Welsh Government with phase one incorporating our highest call categories (Purple Arrest and Red Emergency categories) introduced in July 2025 for life-threatening calls, and from December 2025, new Orange Now, Yellow Soon and Green Planned categories will replace the current Amber and Green categories. The way our service is changing can be explored in more detail on our website.

5.8 The Committee has queried whether WAST has adequate resources to meet the Welsh Government's resilience objectives. Following the publication of the Manchester Arena

Inquiry report (MAI), the Trust has undertaken a review of all the recommendations and instigated a programme of work to implement the recommendations relevant to the organisation. Work relating to learning from the Manchester Arena Inquiry is ongoing and we continue to work with Commissioners, Welsh Government and the wider NHS system on how best to address the full set of applicable recommendations.

5.9 As a national ambulance service, the requirement to fulfil our statutory obligations across four LRFs is challenging. This commitment presented a logistical challenge during the pandemic and remains the case today with feedback from Exercise Pegasus, and Storm Darragh highlighting a lack of coordination between LRFs and logistical challenges presented to WAST with uncoordinated timings of TCGs and SCGs. There are currently in the region of 60 LRF subgroups in existence across Wales, and whilst WAST is not represented on all these subgroups, there will be a significant proportion of them that require ambulance service input. A team of three whole time equivalents Resilience Officers support this structure pan Wales, and this is a feature in the investment case for MAI submitted to the Commissioners for consideration, expected in December 2025.

6. WAST's perspective on the Pan Wales Plan

6.1. The Pan Wales Response Plan sets out the arrangements for the integration, coordination and activation of the Welsh response to an emergency in or affecting Wales. It reflects the principles of response contained in the non-statutory guidance Emergency Response and Recovery which supports the Civil Contingencies Act 2004. The document primarily provides a framework for the management of an emergency affecting several or all areas of Wales. It can also be implemented in response to a major incident in one LRF area. WAST has little experience in the deployment of the pan Wales Response Plan including the activation of the Emergency Co-ordination Centre (Wales) (ECCW) as it was not activated and supported by WAST during the Covid Pandemic or in Exercise Pegasus. We appreciate the need to retain an overarching coordination plan.

6.2. As a national ambulance service, WAST recognises the requirement for coordination pan Wales in the event of an emergency affecting Wales. The requirement for WAST to field

a representative for ECCW under the pan Wales Plan is recognised to aid communication, alongside the inclusion of WAST in any coordinating of response.

6.3. Testing and exercising of any organisational response are essential for organisational "muscle memory", and the incorporation of the pan Wales response into any multi agency or Tier 1 exercise would be beneficial given that the pan Wales Response Plan is largely unfamiliarised with WAST as a Category 1 responder.

6.4. WAST notes from the Wales Resilience Framework report (May 2025) that Welsh Government is committed to undertaking a full review of the pan Wales Response Plan to ensure it remains fit for purpose and reflects recent learning. WAST strongly supports this commitment.

6.5. Servicing multiple LRFs simultaneously presents logistical challenges, particularly for national providers such as WAST. In the absence of resource to react to this challenge, we strongly encourage that the review process considers two key areas for improvement:

6.5.1. Coordination of LRF Meeting Schedules: Establish a system to better coordinate LRF meeting timetables across Wales. This would help to avoid scheduling conflicts and ensure that national providers are able to participate effectively in all relevant meetings.

6.5.2. Single Wales-wide Opportunity: Explore the possibility of providing a once-for-Wales forum or opportunity, which would support national providers in engaging with all LRFs collectively. This approach could streamline communication and enhance efficiency in responding to resilience needs across the country.

6.6. Implementing either of these options would help mitigate the difficulties faced in servicing numerous LRFs concurrently and would strengthen the overall resilience and coordination across Wales.

7. Red Teams

7.1. WAST had previously asked for more information as to 'red teams' on 17 January 2025 (see paragraph 4.1.9). The Special Purpose Committee agreed in their March 2025 report that more clarity was required. It is noted that external 'red teams' are proposed to be regularly used in the Civil Service of the UK government and devolved administrations. Their purpose is to scrutinise and challenge evidence and policies. WAST notes that whilst this is not a new concept it has no experience of them. Through its work responding to the Manchester Arena Inquiry, WAST, with other blue light services, has acted as a critical friend in reviewing each other's major incident plans and has received a Joint Emergency Services Interoperability Programme (JESIP) assurance visit conducted by other blue light partners in November 2023.

7.2. WAST supports the use of red teams and considers that it will serve a useful tool to encourage constructive review and to minimise the risk of biases or blind spots in policy. The implementation and logistics around developing this process are not directly a matter for WAST, but there could be circumstances where policy change is being considered where it is foreseeable that the implications of such change would directly impact WAST service provision. In such circumstances, and where a red team is being proposed to assist, WAST would welcome consultation as to whether external ambulance expertise could usefully be included as part of the red team. In summary, WAST supports the use of red teams but would welcome continued update as to any developments in this area as well as clarity on the extent of this resource and in what situations and circumstances red teams will be deployed.

8. Conclusion

8.1. WAST hopes that these submissions are helpful to the Committee ahead of the meeting on 10 December 2025. If there are any further areas that Members would like the Trust to explore ahead of this then we should be grateful for prior notification so that the necessary preparation can be undertaken.

Dated: 01 December 2025

Welsh NHS Confederation
Conffederasiwn GIG Cymru

	The Welsh NHS Confederation response to the Wales COVID-19 Inquiry Special Purpose Committee - UK-Covid Inquiry Module 1 Report
Contact	Haleema Khan, Policy, and Public Affairs Officer, Welsh NHS Confederation
Date	3rd January 2025

Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Wales COVID-19 Inquiry Special Purpose Committee consultation on the UK Covid Inquiry Module 1 Report.

2. The Welsh NHS Confederation represents the seven Local Health Boards, three NHS Trusts (Velindre University NHS Trust, Welsh Ambulance Services University NHS Trust, and Public Health Wales NHS Trust), and two Special Health Authorities (Digital Health and Care Wales and Health Education and Improvement Wales). The twelve organisations make up our membership. We also host NHS Wales Employers.

The Welsh NHS Confederation's role during the pandemic

3. Due to all Welsh NHS bodies being members of the Welsh NHS Confederation, the Welsh NHS Confederation provided corporate and secretariat support to a number of NHS Wales Executive Director Peer Group meetings prior to the pandemic and during the pandemic. These meetings included Nurse Directors, Public Health Directors, Medical Directors, Assistant Medical Directors and Workforce and Organisational Development Directors. In addition, we provided secretariat support to the NHS Chairs and Vice Chairs meetings and the Chief Executive meetings with the Welsh Government officials, taking a high-level note and sharing it with the Welsh Government and the Chief Executives.

4. These meetings were arranged by the Welsh NHS Confederation on behalf of Peer Group chairs and high levels notes were taken to share with meeting participants. The Welsh NHS Confederation, while in attendance at meetings as an observer, were not involved in any operational matters or decisions made by Welsh Government or our members, the NHS bodies.

5. In addition to supporting members, we work closely with our partners in other parts of the health and care system to ensure we can provide a 'whole system' perspective. We work with members of our Health and Wellbeing Alliance, which include Royal Colleges, third

sector and social care organisations, to provide a system perspective to the Welsh Government and Members of the Senedd.

Views regarding the report's recommendations

Our response to the Committee has been informed by information received from Heads of Emergency Preparedness, Resilience and Response within NHS organisations in Wales. The response considers each recommendation and where there are potential gaps in the recommendations.

Recommendation 1

Members agree with a simplification of the civil emergency preparedness and resilience systems. This could improve overall responsiveness and efficiency of the civil emergency preparedness and resilience systems. The simplification of preparedness mean that decision-making could be potentially more efficient, and resources could be deployed quickly in times of crisis. This could possibly reduce any confusion and delays. Furthermore, members agree that the simplification of resilience could allow for a less complexed and more agile system.

Recommendation 2

Members agree with a new approach to risk assessment. This could help anticipate a wider range of potential threats and allow for identifying any vulnerabilities in the system. This could allow for a better understanding and preparation for several types of crises, beyond pandemics.

Recommendation 3

Members agree with a new UK-wide approach to the development of strategy. This could enable a more coordinated and integrated approach to strategy development, ensuring that lessons identified from past events are incorporated into future planning. To ensure there is better alignment in approach in recommendation three, members suggest that addressing inequalities and vulnerabilities is important to understand how different communities are affected by crises. Moreover, members emphasise that better alignment in approach to resilience and recovery and collaboration is key. Collaboration is one of the statutory duties included in the Civil Contingency Act, 2004.

Recommendation 4

Members agree with improving systems of data collection and sharing in advance of future pandemics, and the commissioning of a wider range of research projects. Members suggest that to facilitate better systems of data collection, the aim should be to gather and disseminate critical information ahead of potential pandemics or other emergencies, fostering better preparedness and response. Also, this could aid commissioning of research. Timely, accurate data is critical for effective crisis management and allows for the ability to quickly adapt to changing situations.

Recommendation 5

Members agree with holding a UK-wide pandemic response exercise at least every three years and that the outcomes of these exercises are published. This could help stimulate potential scenarios to test and refine the nation's response capabilities, with the results being published to maintain transparency and accountability. This is linked at UK, Wales, regional and local levels. It could also help identify gaps in response and enhances the system's overall resilience.

Recommendation 6

Members agree with bringing external expertise from outside government and the Civil Service. Members suggest Red Teams for more creative or critical thinking, also to potentially avoid biases or blind spots in policy.

Recommendation 7

Members agree with the publication of regular reports on the system of civil emergency preparedness and resilience. Our members believe that this recommendation intends for more transparency and accountability through regular reporting and monitoring.

Recommendation 8

Members agree with the creation of a single, independent statutory body for responsibility for whole system preparedness and response. This recommends the establishment of an independent body dedicated to overseeing the entire Emergency preparedness, resilience, and response (EPRR) system which members highlighted may add strength to EPRR as a body. Also, members emphasised that this allows for oversight and the need to understand the value of this in addition to the architecture that is already in place.

Other potential gaps for the committee to consider

Localised Preparedness

Members agree that there are gaps in localised preparedness. Our members suggest that it is important to not lose sight that there will be local issues that need addressing and that oversight is not limited to a national scale.

Resource Allocation and Funding

Our members have stated that there are gaps in resource allocation and funding for preparedness. Our members have highlighted this recommendation does not identify how resource and funding allocation will be made in the future.

Psychosocial and Public Health Resilience

Members agree that there are gaps in psychosocial and public health resilience. There has been an emphasis from our member on the wider preparedness, particularly regarding mental health and social cohesion to be considered.

Integration with Global Efforts

Members suggested that there are gaps in this recommendation. Our members have stated the need for alignment with international frameworks (such as the WHO) when it comes to integration with global efforts.

Resource requirements to close gaps

Our members have emphasis resources requirements to close gaps. Members have suggested adequate staffing of EPRR equipped with the right skills and knowledge, dedicated funding to deliver on statutory duties and investment in securing data infrastructure.

Knowledge and Expertise

Our members have identified gaps in the knowledge and expertise recommendation. Members have highlighted the importance of bringing in experts from academia as well as from multi-agency fora.

Evaluation

On evaluation, members have suggested that it is important to conduct independent evaluations after each national pandemic exercise or critical incidents.

Public and Stakeholder Reporting

Regarding public and stakeholder reporting, members have highlighted the need to have regular publication of reports on the state of EPRR preparedness.

Feedback to: Resilience and Community

On Feedback to: Resilience and Community, members have emphasised establishing feedback links for those in resilience and the communities.

Independent Oversight

Regarding independent oversight, members have highlighted that it is crucial for ongoing monitoring to ensure that recommendations are followed, and that there is a mechanism for accountability. For example, regular publication of reports on EPRR (Recommendation 7) is an essential component in Civil Contingencies and ensures transparency and accountability at Board level.

Moreover, our members have stated that addressing these recommendations could build further to be a highly resilient and well-prepared system that can respond swiftly and effectively to future crises.

Written statement of the Covid-19 Bereaved Families for Justice (CBFJ Cymru) to the Public Accounts and Public Administration Committee (the Committee)

1. The purpose of this statement of the CBFJ Cymru is threefold:

    a. First, to seek to assist the Committee's understanding of the Covid-19 pandemic issues in Wales that urgently require Welsh specific scrutiny.
    b. Second, to demonstrate why the proposal to examine gaps identified in the preparedness and response of the Welsh Government and other Welsh public bodies during the Covid-19 pandemic, with reference to the reports of the UK Covid-19 Inquiry, is an ineffective and inadequate process for scrutinizing these issues.
    c. Third, to explain the advantages of CBFJ Cymru's preferred approach of a focused Welsh specific statutory inquiry.

Disadvantages of the gap analysis approach

Procedural disadvantages

2. As the Committee is aware the UK Inquiry has adopted a modular approach to its work, across 13 Modules as follows:

    - Module 1 – Resilience and preparedness
    - Module 2 – Core UK decision making and political governance
    - Module 2A - Scotland
    - Module 2B - Wales
    - Module 2C – Northern Ireland
    - Module 3 – Impact on healthcare systems
    - Module 4 – Vaccines and Therapeutics
    - Module 5 - Procurement
    - Module 6 – Care Sector
    - Module 7 – Test Trace and Isolate
    - Module 8 – Children and Young People
    - Module 9 – Economic response
    - Module10 – Impact on society

3. The stage reached by the UK Inquiry as at the date of this statement is that evidence hearings have been completed for Modules 1-8, with the remaining hearings to be completed by March 2026. The Module 1 report was published on 18 July 2024, and a report for Modules 2, 2A, 2B, and 2C was published recently on 20 November 2025.

4. CBFJ Cymru has been pleased to be designated a core participant to Modules 1, 2, 2B, 3, 4, 5, 6, 7, and 10, and has taken an active role, carefully scrutinising the evidence disclosed in these Modules by the Inquiry.

5. The scope of the UK Inquiry is extremely wide and it has gathered a huge amount of witness and documentary evidence, including a significant amount from the Welsh Government and Welsh public bodies.

6. This wide scope has necessitated the UK Inquiry's Modular approach (to divide the work into manageable sections). However, while recognizing the need to divide and stagger the work of the UK Inquiry, there are several drawbacks to this approach that can and should be avoided when scrutinising pandemic issues in Wales.

7. To date, just two reports have been produced by the UK Inquiry, and it will be some time before the remaining reports of the Inquiry are published. If Welsh specific scrutiny only takes place following publication of a UK Inquiry report, this will unnecessarily embed delay into the process, in circumstances where Welsh specific scrutiny ought to be commenced immediately, as is taking place in Scotland through the Scottish Covid-19 Inquiry.

8. Further, the Modular approach has involved significant duplication and repetition across multiple Modules, with the same witnesses producing separate witness statements for each Module, providing oral evidence on multiple occasions, and with the same issues requiring repeated consideration, e.g. PPE, testing, methods of transmission etc.

9. The size and scope of the evidence gathering exercise, and the need to stagger hearings at the UK Inquiry has also resulted in issues being considered out of context. For example, some of the most serious incidences of a lack of preparedness in Wales that resulted in the unnecessary loss of many lives, were the failure to maintain an adequate stockpile of PPE and the lack of testing capability and capacity in Wales. However, because of the way the UK Inquiry structured its work there was no meaningful consideration of these issues during Module 1. Instead the Module 1 report recommendations are heavily focused on civil emergency structures (largely as a product of an analysis of UK Government) which while important, do not, in CBFJ Cymru's view, go to the heart of the failings of resilience and preparedness in Wales (as explained in more detail in the next section).

10. By unnecessarily mirroring the UK processes, the much needed Welsh specific scrutiny will be delayed, and will follow a sequence that makes no sense for Wales, and kicks the can down the road for many years to come, rather than urgently grappling with the issues that need to be addressed now.

Evidential disadvantages

11. As already mentioned, the UK Inquiry's work in Module 1 was not able to consider key aspects of the lack of preparedness across the UK. Further, the UK Inquiry's consideration of Welsh specific issues is limited (by necessity) and its main focus has been on the UK Government. While entirely understandable (having regard to the scale of the task), this has meant that there has been an absence of Welsh specific scrutiny. This problem is common to other devolved governments, and this gap has been filled in Scotland with their own Inquiry, that is able to focus on the issues of most importance to Scotland and to devise their processes accordingly.

12. Blindly following the UK Inquiry process is not an adequate solution for Wales and will result in a failure to identify the actions that are needed in Wales in the public interest to ensure that we never experience such devasting and needless loss of life again. We need our own national Inquiry, as in Scotland.

13. An example of the way in which CBFJ Cymru considers that spending time examining Welsh gaps in the work of the UK Inquiry in Module 1 is not the best use of time and public resource, are the first and second recommendations of the Module 1 report, which are as follows:

    Recommendation 1

    The governments of the UK, Scotland, Wales and Northern Ireland should each simplify and reduce the number of structures with responsibility for preparing for and building resilience to whole-system emergencies.

    The core structures should be:

    - *A single Cabinet-level or equivalent ministerial committee (including the senior minister responsible for health and social care) responsible for whole-system civil emergency preparedness and resilience for each government, which meets regularly and is chaired by the leader or deputy leader of the relevant government, and*
    - *A single cross-departmental group of senior officials in each government (which reports regularly to the Cabinet-level or equivalent ministerial committee) to oversee and implement policy on civil emergency preparedness and resilience.*

    Recommendation 2

    The UK government should:

    - *abolish the lead government department model for whole-system civil emergency preparedness and resilience; and*
    - *require the Cabinet Office to lead on preparing for and building resilience to whole-system civil emergencies across UK government departments, including monitoring the preparedness and resilience of other departments, supporting departments to correct problems, and escalating issues to the UK Cabinet-level ministerial committee and group of senior officials in Recommendation 1.*

14. It will be readily apparent that these recommendations are focused on the UK government, and CBFJ Cymru's view is that they mainly arise out of problems identified with the system operated by the UK Government (not the system in Wales).

15. The Welsh Government responded to these recommendations on 16 January 2025. The responses included initiating the Wales Resilience Framework programme to enhance governance and clarify roles within the emergency preparedness system. And specifically with reference to Recommendation 2 (which on a strict reading has no relevance to Wales) the Welsh Government maintained its adherence to the lead government department model, but indicated that different models would be considered in the event of a prolonged whole-system emergency.

16. CBFJ Cymru's position in relation to these issues is that there is no requirement for additional Welsh specific scrutiny, and the group makes the following observations:

    a. These recommendations are in reality directed at the UK Government, and have been cross-applied to devolved governments.

    b. Welsh government is constituted and operates very differently from UK Government, for example it is much smaller and more cohesive. In these circumstances CBFJ Cymru considers that the Wales Resilience Framework programme is an adequate response to Recommendation 1, and we do not take issue with the Welsh Government's rejection of Recommendation 2.

17. The circumstances requiring urgent Welsh specific scrutiny in respect of resilience and preparedness, are not whether the lead department model should be maintained or abolished, but the quality of the leadership of those responsible for these issues within the Welsh Government prior to and during the pandemic.

18. The Committee will note the importance ascribed by the UK Inquiry Chair to the role of the minister responsible for health and social care (identified within Recommendation 1 as an essential member of any ministerial committee responsible for whole-system civil emergency preparedness and resilience). Within Wales this was Vaughan Gething, who served from September 2014 as Deputy Minister for Health, from May 2016 as Cabinet Secretary for Health, Well-being and Sport, and then as Minister for Health and Social Services until May 2021.

19. In Mr Gething's evidence to the UK Inquiry (all of which is publicly available) he told the Inquiry that he had not understood that pandemic risk was in the Tier one risk register. He did not read the National Risk Register. He had not read the 2011 Influenza Strategy before or during the pandemic. He had also not read the report on the outcome of Exercise Cygnus, which sought to assess the impact of an influenza pandemic.

20. During the oral evidence of Mr Gething there was the following extraordinary passage of questioning from Counsel to the Inquiry (Day 14 of the Module 1 hearings, 4 July 2023, at pages 119-121 of the publicly available transcript):

> *Q. You tell us at paragraph 37 in your witness statement:*
> *"My impression of the Plan, as a layman and someone without any previous experience or knowledge of pandemic preparedness, was that it was considered and reasonable. I do not think I first saw it [as we've established] until January 2020."*
>
> *Q. Is it right, Mr Gething, to describe yourself as a layman when you had been the Cabinet Minister for Health since 2016?*
>
> *A. I'm describing myself in comparison to, for example, the people you've already heard evidence from. I wasn't the*

Chief Medical Officer or the Medical Director of Public Health Wales or the people involved in emergency planning, so in that sense it is a lay perspective, but obviously compared to the wider population I've got experience in government of doing a range of things.

Q. Describing yourself as having no previous experience or knowledge of pandemic preparedness when you had been four years in post might be surprising to some people.

A. Again, I think if ... I'm trying to be clear about the difference between myself and people involved in the detail of emergency planning. So compared to the general population, I certainly had more experience and knowledge, and I'm trying to be clear about that distinction rather than trying to go beyond it.

Q. What level of contact did you have with the Chief Scientific Adviser for Health, Dr Rob Orford?

A. I saw Dr Orford on a number of occasions through the year. So in the pattern of that sort of engagement, I would have a regular meeting with the Chief Executive of NHS Wales, I'd have a regular meeting, normally at least monthly, with the Chief Medical Officer, sometimes sooner, and for some officials like Dr Orford I'd probably see them three or four times a year in set meetings. So, for example, some of the points that have been described around investing in our genomics capacity, some of that came from conversations with Dr Orford and Dr Atherton about what we needed to do. So I was -- I knew who Rob was, I'd met him on several occasions before we get into the depths of the Covid pandemic.

Q. Between you taking office in 2016 and the onset of the pandemic in 2020, were you aware that the Chief Scientific Adviser for Health had no involvement in pandemic preparedness planning?

A. No, I wasn't aware of that specifically, no.

Q. Does that surprise you?

A. In retrospect, it is, because he had such a role in giving advice to ministers when we actually had to deal with the scale of the pandemic.

Q. Were you aware during your time in office of the Welsh Government risk register?

A. Yes, I knew we had a Welsh Government risk register.

Q. Did you ever read it?

A. No.

Q. Were you aware of the Health and Social Services Group risk register?

A. Yes, and I would discuss that from time to time as(?) it was raised with me by the Director General at the time, obviously who was Dr Goodall.

Q. Did you read it?

A. No, I don't think I did go through and read the risk register.

21. CBFJ Cymru has no wish to personalise the issues unnecessarily, but we would respectfully suggest that it will be a far more worthwhile effort to probe and scrutinise the complete absence of ministerial oversight of pandemic preparedness and resilience by those in Wales who were responsible, rather than further consider the merits or otherwise of the lead department model. Together with the First Minister, the Minister for Health and Social Services was the most important role in Wales during the pandemic (and in respect of pandemic preparedness). For there to have been this level of ignorance is indefensible and requires further examination in Wales. When CBFJ Cymru members heard the evidence reproduced above (which is sadly not an isolated example) we became extremely distressed and angry to know that there was such a lack of grip of these issues within the heart of the Welsh Government.

22. CBFJ Cymru suggests that the real focus of any Welsh specific inquiry into the lack of pandemic resilience and preparation in Wales ought to be focused on:

    a. Why there was insufficient equipment within the Welsh PPE stockpile?
    b. Why there was no capacity and capability to test and trace in Wales?
    c. Why was local public health expertise in Wales not fully harnessed to combat the spread of Covid-19?
    d. Why were hospitals and care homes in Wales so unsuitable and incapable of preventing the spread of infection such that they were the least safe places in the country during the pandemic, with infections rates many times those than in the community, and which resulted in many thousands of deaths from nosocomial infection?

23. These are the key issues that need to be scrutinised in Wales in connection with a lack of preparedness and resilience. None of these issues are reflected within the recommendations of the UK Inquiry's M1 report, and our respectful challenge to the Committee is, why waste time and public money on issues which are not the main priority for Wales?

The UK Inquiry's Module 2, 2A, 2B, and 2C report

24. It is appreciated that the focus of the work of the Committee is on the UK Inquiry's Module 1 report and the issue of preparedness and resilience. However, we ask the Committee to take account of the recently published Module 2, 2A, 2B, and 2C report of the UK Inquiry, "Core decision making and political governance" (the Module 2 report) because the absence of any detailed analysis of Welsh Government decision making dispels any idea that a gap analysis of the UK Inquiry report will provide sufficient scrutiny to give an understanding of what went wrong in Wales, and for lessons to be learned for the benefit of the people of Wales.

25. The lack of Welsh specific content within the UK Inquiry report is stark (despite three weeks of hearings in Cardiff) and is a further example of how Welsh issues become lost in the wider context of a UK Inquiry.

26. Accepting that the UK Inquiry deliberately decided not to provide separate Module 2 reports for each country, there are nevertheless just seven Welsh specific sections within the Module 2 report, the longest of which is just seven pages, and three of the Welsh specific sections are comprised of just a single paragraph.

27. Given the absence of Welsh specific scrutiny in the UK Inquiry's reports, CBFJ Cymru seek a Welsh specific inquiry to build on the large volume of foundational evidence gathered by the UK Inquiry to develop a process that is focused on the issues that really matter in Wales and to provide the scrutiny that so far has been missing.

The CBFJ Cymru's suggested approach

28. As repeatedly stated, CBFJ Cymru firmly believes that what is needed is a Welsh specific inquiry into the Welsh Government's preparedness and response to the Covid-19 pandemic, just as has been set up in Scotland.

29. We respectfully submit that given that these are predominantly devolved issues it is absurd that they are not being properly considered and that solutions are not being developed within Wales for the benefit of the Welsh public.

30. CBFJ Cymru does not seek to duplicate the work already carried out by the UK Inquiry, but to build on it by providing scrutiny through a Welsh specific lens of the issues that are of most importance. CBFJ Cymru firmly believes that this necessary scrutiny will be lacking unless it is carried out in Wales.

31. Much of the preparation has already been undertaken with very significant amounts of disclosure and witness statement evidence having been provided to the UK Inquiry that can be easily obtained, within a short time period, by a Welsh public inquiry. There will inevitably be a need to make supplementary requests for information, but the bulk of the evidence gathering work is already done.

32. Having spent the last three and a half years immersed in the work of the UK Inquiry, CBFJ Cymru has gained considerable insight into the issues that are of most concern in Wales, and we suggest that a Welsh Inquiry can be targeted, efficient and effective by focusing on the following issues:

    a. Ascertain, as far as practicable, the likely numbers of people in Wales who died in circumstances that a Covid-19 infection was the cause or a contributory cause, of death.

    b. Consider the nature and quality of the information provided to bereaved families about the cause of death, including but not limited to coronial scrutiny and examinations undertaken by medical examiners in Wales.

    c. Ascertain, as far as practicable, the likely numbers of people in Wales that acquired a Covid-19 infection while an in-patient in hospital and/or a resident in a care home.

d. Take account of the work of the National Nosocomial COVID-19 Programme and its investigation of 18,360 cases of nosocomial Covid-19.

e. Ascertain, as far as practicable, the likely numbers of people in Wales that acquired Long Covid.

f. Consider the state and adequacy of pandemic and medical emergency preparations in Wales, including but not limited to, ICU capacity, Personal Protective Equipment (PPE) stockpiles, and testing capability and capacity.

g. Consider the adequacy of Infection prevention and control measures within health and social care settings in Wales, to include but not limited to, PPE, isolation, ventilation, and the fitness for purpose of the health and social care estates.

h. Consider the nature, quality, and timeliness of scientific and clinical advice provided to Welsh Government Ministers, and its use by Ministers. To include whether a sufficiently precautionary approach was adopted, in particular, but not limited to, the known risks of asymptomatic and airborne transmission.

i. Carry out a detailed examination of testing policy in Wales, including but not limited to testing eligibility and reliance on limited symptoms, whether the testing of patients, care home residents, and health and social care staff could and should have been implemented sooner, and the extent to which the publicly expressed views of Ministers on the efficacy of testing were genuine and reasonably held beliefs.

j. Consider the adequacy of decisions and actions taken following the peak of wave 1 to prepare for and reduce infections and fatalities in wave 2.

k. Consider the decisions to delay the provision of the Pfizer vaccine to care home residents on 25 November 2020, and the decision on 15 December 2020 to allow patients who tested positive for Covid-19 to be discharged to care homes, and to determine, so far as practicable, the impact of these decisions on care home residents.

l. Consider whether adequate steps were taken to protect and treat the elderly and vulnerable, and the extent to which they were deprioritised, including in relation to the availability treatment, equipment and palliative care.

m. Examine whether there have been attempts to conceal details of what happened in Wales whether by destroying or withholding information, or through a lack of openness or candour.

Covid-19 pandemic issues specific to Wales

33. In this section, we provide more detail of a select number of priority issues requiring Welsh specific scrutiny, to further illustrate why a Welsh public inquiry is required.

<u>Investigations into nosocomial deaths in hospitals and care homes in Wales</u>

34. This is an incredibly important and emotive issue for many CBFJ Cymru members. Many predominantly elderly and vulnerable family members were admitted to hospitals in Wales for essential medical treatment and due to poor infection prevention and control (IPC) and PPE they became infected with Covid-19 and died. Common themes include families seeking assurances that their family member would not be placed in a bed near to Covid-19 infected patients, only to find out later that such assurances were not kept and despite their vulnerabilities they had been accommodated on wards with Covid-19 infected patients and unnecessarily exposed to the virus. It is circumstances such as these that drives the group's concerns at the wholly inadequate IPC, PPE, ventilation, and testing regimes in hospitals, particularly given the airborne

nature of the virus (the risk of which was known from the outset of the pandemic but not acted upon).

35. CBFJ Cymru campaigned extensively for *an* investigation into Covid-19 nosocomial infections in Wales, and we met with the former First Minister, Mark Drakeford in October and December 2021, and again in January 2022, around which time the National Nosocomial Covid-19 Programme was announced.

36. The Welsh Government's press release from 26 January 2022 (which remains available online) states as follows:

> *"More than £4.5m is being invested into a programme investigating hospital-acquired Covid-19 infections in Wales.*
>
> *Health Minister Eluned Morgan has pledged that all incidents of COVID-19 caught in hospitals will be investigated and lessons will be learnt to reduce the chances of it happening to anyone else.*
>
> *The funding will go towards supporting a framework used by health boards to report and investigate hospital-acquired infections. Wales is the only nation in the UK to record every incident of a hospital-acquired infection - also known as nosocomial infections - via the ICNET database.*
>
> *The investment over two years will support health boards and the NHS Delivery Unit to take forward an important and complex programme of investigation work into cases of hospital-acquired COVID-19.*
>
> *Throughout the pandemic the NHS in Wales has worked incredibly hard to do all it can to keep the virus out of hospitals and to protect people being cared for, often in very difficult circumstances.*
>
> *This has included rigorous infection control procedures in place in all NHS settings, including hospitals; free PPE available to all NHS and social care services; extensive guidance issued about social distancing, bed spacing, staff and patient testing, ventilation and mask wearing; and multiple checks undertaken by health boards, Healthcare Inspectorate Wales and the Health and Safety Executive.*
>
> *However, despite the best efforts of healthcare staff doing their utmost to deliver care and prevent transmission of a highly infectious virus, and all these measures being in place combined with prioritised testing of healthcare workers, COVID-19 infections have been contracted in hospitals.*

They account for around 1% of all COVID-19 infections. Very sadly, in some cases, some people have come to harm or died after acquiring COVID-19 in hospitals.

NHS Wales has been committed to investigating hospital-acquired COVID infections throughout the pandemic, with families affected encouraged to contribute to the "Putting Things Right" process and The Nosocomial Transmission Group set up in May 2020 to help prevent infections through learning and publishing a national framework in relation to patient safety incidents of hospital acquired COVID-19.

Health Minister Eluned Morgan said:
Our NHS in Wales has worked incredibly hard to keep the virus out of hospital settings, but unfortunately it has been impossible to achieve this.

With high rates of community transmission outside of hospitals during various periods of the pandemic, it has been a monumental task to prevent COVID-19 entering our healthcare settings and spreading to those receiving care in them.
We know that in some cases patients have experienced harm or died after catching COVID-19 in hospital settings, and we are deeply saddened by all those who have been affected by this.

We are investing in this framework as we are determined to not only investigate into every case of hospital-acquired COVID-19 infection, but learn why it happened so we can do everything in our powers to prevent it from happening again. It will also be reviewed in two years due to the evolving nature of the pandemic."

37. It will be seen from this press release that the Welsh Government made the following claims:
    a. that Wales was the only UK nation to record every incident of a hospital-acquired infection;
    b. that all incidents of Covid-19 caught in hospitals will be investigated;
    c. that the £4.5 million investment (per year over two years, totalling £9 million) was for the purpose of supporting Health Boards and the NHS Delivery Unit to take forward an important and complex programme of investigation work into cases of hospital-acquired Covid-19; and
    d. that the NHS in Wales did all it could to keep the virus out of hospitals.

38. When the National Nosocomial Covid-19 Programme was announced, group members were overjoyed and some of us cried with relief. Deputy Chief Medical Officer Chris Jones told us in a meeting that he had advised the Welsh Government that all deaths from nosocomial infection needed to be recorded as Patient Safety Incidents, hence the need for individual responses.

39. However, we quickly became frustrated at the lack of progress with the Programme, and our fears about the adequacy of the investigations have unfortunately been realised. Only those who had made a complaint got a report, and an investigation into every incident of a hospital-acquired infection has not taken place despite the "pledge" to do so by the then Health Minister and now First Minister, Eluned Morgan.

40. Many reports provided to bereaved families contradict the death certificate and/or medical notes, and fail to identify failures. Not a single cluster outbreak was investigated, despite there being hundreds.

41. An End of Programme Learning Report was published in August 2024, and prior to this an Interim Learning Report was produced in March 2023 (both annexed to this statement at annexes 1 and 2).

42. Despite the size of the budget and the importance of the undertaking, the Interim Learning Report (which at the date of publication in March 2023 purported to have assessed over 5,000 cases) is just 16 pages and the End of Programme Learning report (which claims to have assessed some 18,360 cases) is just 24 pages.

43. At page 4 of the End of Programme report it is stated that 18,360 cases that met the definition of a patient safety incident were investigated. However, CBFJ Cymru is doubtful of these claims, and we know from our membership that not all cases of death resulting from a Covid-19 nosocomial hospital acquired infection were investigated.

44. The inadequacies of the report and the absence of specific findings have shocked bereaved families in Wales, who had understood that the Programme would include a comprehensive investigation of the circumstances of

individual deaths following a nosocomial Covid-19 infection, rather than what we now suspect to be a box ticking exercise to satisfy the legal obligation to record Patient Safety Incidents.

45. We set out below the key findings of the Interim and Final reports to demonstrate just how rudimentary and generic they are, as follows:

    a. "The NNCP [the Programme] was established in April 2022 to support NHS Wales organisations to conduct proportionate investigations into patient safety incidents of nosocomial COVID-19, which occurred between March 2020 and April 2022" and "[a] commitment by NHS Wales to investigate and answer as many questions as possible…" (page 4 of the Interim Learning Report).

    b. "To date, the framework has supported NHS Wales organisations to assess and investigate over 5,000 cases of nosocomial COVID-19 where they met the definition of a patient safety incident." (page 4 of the Interim Learning Report).

    c. "…a *Capturing Experience Through the National Nosocomial COVID-19 Programme* plan has been developed to further support and enhance people's voices in the process…" (page 5 of the Interim Learning Report).

    d. "**Key learning**: Bereavement support services should be proactively made available to all families, particularly for those where there may be a link with an associated patient safety incident" (page 6 of the Interim Learning Report).

    e. In respect of supporting service users during an investigation process - "**Key learning**: Every service user, family and carer should have timely access to a dedicated and easy-to-access single point of contact to provide feedback, and raise questions, concerns or queries." (page 7 of the Interim Learning Report).

f. In respect of visiting restrictions – "**Key learning**: All services and wards should have named and dedicated patient support teams and volunteers to support service users, families and carers who may be finding it difficult to visit a loved one in hospital." (page 8 of the Interim Learning Report).

g. In respect of IPC and outbreak management – "Testing can be an important mechanism in the identification and prevention of infectious diseases…Demand exceeded capacity and the inability to test rapidly for COVID-19 during periods of 2020, meant that testing was somewhat ineffective as a mechanism for reducing infections until the supply of consumables met demand and testing capacity increased." (page 12 of the Interim Learning Report). "While a testing strategy produced by the Welsh Government was launched on 15th July 2020, significant challenges in applying the policy existed due to limited access to the volume of consumable items required to undertake tests, and laboratory capacity to manage the extreme demand. Additional capacity beyond the existing infrastructure was achieved with the launch of the lighthouse laboratory (IP5), towards the end of August 2020, this meant it became easier and quicker to test patients and staff for COVID-19. As well as testing, isolation plays an important part in preventing and controlling the spread of infections, especially in healthcare settings. Timely testing, along with the ability to isolate suspected or positive patients can aid in preventing onward transmission…An aged estate and limited isolation facilities (such as access to single rooms) meant that patients were often unable to be isolated in single rooms, and cohorting was established to maintain operational flow through hospitals due to extreme demand. The inability to isolate patients often meant that, in an attempt to reduce spread of infections, service users were subjected to multiple ward movements." (page 13 of the Interim Learning Report).

h. "Over the course of the two-year programme, the framework has supported NHS Wales organisations to assess and investigate a total of 18,360 cases of nosocomial COVID-19 where they met the definition of

a patient safety incident." (page 4 of the End of Programme Learning Report).

i. "**Key learning**: For clinical records to be completed to a high standard, clinical staff need the time to focus their attention on record keeping. There may also be wider value in reaffirming to clinical staff the value in record keeping and how it supports the patient safety agenda and investigation processes." (page 14 of the End of Programme Learning Report).

j. "Despite best efforts, staffing levels were under significant strain, and at some points, NHS Wales organisations were not able to maintain safe staffing levels. The unintended consequences of this…were risks to patient safety and sub-optimal care" (page 16 of the End of Programme Learning Report).

k. "Bed-spacing and ventilation were also a challenge in some areas which limited the ability to manage the risk of infection…the pandemic and subsequent learning has highlighted the impact modern estate design, such as the availability of single rooms, can have on the strengthening IP&C." (page 22 of the End of Programme Learning Report).

46. While the Interim and End of Programme reports do make observations about the benefits of testing, isolation and ventilation, and the problems of an ageing estate and staff shortages, they are of an incredibly general nature and provide no new insights. For this to be product of a £9 million national nosocomial programme is a national disgrace. They tell us nothing about the circumstances in which our loved ones were exposed to the risk of infection while in healthcare settings, for example, the levels of infection on wards, the extent to which PPE/RPE was available and complied with, any efforts made to improve ventilation, the use of and compliance with testing (of both patients and staff), and the delay to regular testing, the availability of isolation facilities and the measures taken once infections on non-Covid wards were identified, consideration of the risks of staff movements, protections in place for clinically

vulnerable, and extremely vulnerable patients, and an examination of the many instances of cluster outbreaks in hospitals across Wales, etc. This was what we understood the purpose of the Programme was to be. Instead, we have been provided with a series of general statements about rudimentary IPC practices.

47. Further, while we understand that the individual reports provided to bereaved families cannot be disclosed having regard to confidentiality and data protection issues, there has been no meaningful analysis of these individual reports to identify thematic issues (while maintaining confidentiality) so that health services in Wales can be improved in accordance with the publicly stated intention to "learn why it happened so we can do everything in our powers to prevent it from happening again". For example: to determine how many hospital patients were infected and died following cluster outbreaks; how many patients were infected and died following exposure to Covid-19 positive patients on their ward; the dates on which routine testing of patients and staff were introduced at all hospitals across Wales (twice weekly testing of staff in Wales was required from mid December 2020 but was not implemented by most hospitals in Wales until much later) and the impact of these failures of compliance on infection levels; and how many of the 18,360 cases of hospital acquired Covid-19 were the subject of an investigation report .

48. The abject failure of the Programme is a glaring example of the failure of the Welsh Government to live up to their lofty rhetoric and promises, and it has prolonged our bereavement.

49. We seek a Welsh public inquiry that will be able to access the investigation records of the National Nosocomial Covid-19 Programme, and shine a light on the extent of the failures to protect patients in Welsh hospitals. This is all the more important as no investigation through inquests has taken place to date, even in the circumstances of cluster outbreaks and deaths.

50. We were also promised a care home investigation by Mark Drakeford during a face to face meeting with him at Welsh Government buildings on 30 August 2022. He agreed that "just because it is difficult, it doesn't mean it shouldn't

happen". To date nothing has been delivered. We sent 18 chaser emails following the meeting, and all that was done was that the Welsh Government issued a form to advise care homes on how to deal with complaints.

The inadequacy of the Welsh PPE stockpile

51. The Welsh PPE stockpile was seriously deficient, and is a glaring failure of preparation and resilience.

52. The quantities of stock held were woefully inadequate to withstand a pandemic. The lack of FFP3 respirators (which were needed in health and social care settings to protect against an airborne virus such as Covid-19) were a particular concern, and Wales had the lowest levels of this equipment across the UK. To put this in context, despite having almost double the population of Northern Ireland, Wales had only 10% of their supply of FFP3 respirators.

53. The shortage of FFP3 respirators in Wales led to the extraordinary step of using out of date stock as a last resort, which when tested in February 2020, were found to fail at a rate of 50%, largely because they did not fit the female face.

54. Given that over 70% of the health and social workforce are women, this failure rate is highly troubling. Plainly, if the masks do not fit the significant majority of health and social care workers, they provide little protection against the spread of airborne viruses in health and social care settings.

55. Further, the contingency planning to supplement the stockpile through Just-in-Time contracts was flawed, and these Just-in-Time arrangements collapsed in the face of global competition during the pandemic (an entirely predictable outcome that was never recognised or planned for by the Welsh Government).

Testing policy and reliance on "the science" in Wales

56. Testing decisions and policy in Wales were slow, dysfunctional, reactionary, and false statements were made to justify not implementing testing sooner.

57. These failings are most clearly demonstrated in connection with care homes, with hospital patients discharged into care homes with Covid-19 without testing (thus seeding the deadly infection into the most vulnerable communities in Wales) and in connection with the failure to implement asymptomatic testing in care homes until it was too late.

58. In both cases the reason for the failure to test was because there was no testing capacity in Wales (another glaring failure of resilience and preparedness). However, the Welsh Government blamed, "the science" because otherwise they would have had to admit their failure.

59. This is a complicated issue, but the evidence is now publicly available. In short, the former First Minister, Mark Drakeford, made false statements in the Senedd when claiming on 29 April and 6 May 2020 that there was no clinical value in routine asymptomatic testing in care homes. Whereas it was well known from mid-April that Covid-19 was transmitting at high levels asymptomatically and that asymptomatic testing was required to protect care home residents.

60. The absurd views expressed by Mr Drakeford caused serious concerns within the scientific community in Wales, and in response Peter Halligan, the Chief Scientific Adviser for Wales, caused an email to be sent to Dr Rob Orford and Fliss Bennee on 30 April 2020 upon hearing them, which reads, "*Dear Rob, Fliss, Peter Halligan is keen to understand the rationale, evidence and advice behind the First Minister's comments last night on the telly that there is no value to testing for Cov-19 in care homes. Please can you enlighten us.*"

61. Mr Drakeford was not alone in making such false statements. During a question-and-answer session on 23 June 2020 (publicly available on video[1]) Mr Gething was asked the question, "*The Welsh Government has said that the scientific advice was it would not be a good use of testing capacity to test asymptomatic patients until the end of April. If it was the case that there was a lack of testing capacity that caused this advice, was it the fact that there wasn't enough tests that meant you made the decision to not test people who*

[1] Available online at: https://www.pscp.tv/w/ezWTDDFQWEtkcVlYUE12amV8MUJkR1lucGxlUXpKWLE3rNHhjg9n66M2-KewlRuVYm1X1irTs17IPwFADyn2?t=fRzf-wyHbUrKP8mCtK_gLQ&s=03

were going into care homes until the end of April?" To which Mr Gething responded, "*No…we based our decisions on advice and evidence*". The journalist continued, "*Surely if you'd had enough tests to have been able to test everyone, you should have been testing everybody who went from a hospital into a care home. And it was the fact that you didn't have enough tests that made that advice the advice that it was at the time*". Which elicited a similar response from Mr Gething, "*No…you're just wrong…if we had treble the amount of testing capacity…then that was still the evidence and advice that we had…we didn't get advice that said, 'you really should do this but you can't because you don't have testing capacity'*".

62. What so incenses the members of CBFJ Cymru is that the continued false claims of the Welsh Government that their policy was based on science and not a lack of capacity is for the purpose of evading responsibility, and in doing so not only does it demonstrate a lack of integrity and accountability, it risks failing to learn from past mistakes. If the truth is acknowledged, it will be clear that better preparation could have avoided the severity of the impacts of the pandemic, but unless this is done, we are destined to repeat the same mistakes in Wales. The tragedy of the approach of Welsh Government is that it puts the reputations of a small number of Welsh politicians above the wider public interest.

63. CBFJ Cymru considers that the misrepresentation of scientific issues in this way is a matter of very grave concern and is a key aspect of core decision making in Wales that requires careful scrutiny.

64. While this issue has received little consideration within the UK Inquiry's Module 2 report, the report does cite an example of this tendency at paragraph 2.205, which records that Mark Drakeford knew that in mid-February testing capacity in Wales was just 100 tests per day and that this was not going to be sufficient for a mass testing regime. Yet, despite this knowledge, just two weeks later on 2 March 2020, Mr Drakeford stated in a press conference that Wales was **well prepared** and that robust infection measures were in place to protect public health in Wales (see paragraph 3.19 of the Module 2 report).

65. The one public health measure that might have made a difference to the appalling outcomes in Wales was a robust testing regime (as seen in countries such as Singapore and South Korea and as confirmed by the World Health Organization who advised countries to test, test, test). However, Wales could not do this because it had almost no testing capacity, caused by years of neglect and a failure to prepare.

66. This false statement that Wales was well prepared (when nothing could have been further from the truth) is not an isolated example (as seen from the additional examples above and in the section below on vaccinations) and they need to be considered together when assessing the nature of Welsh Government decision making and communications with the public. This has not been done in the UK Inquiry and it needs to be a focus of a Welsh Inquiry.

67. Following publication of the Module 2 report, Mr Drakeford defended the Welsh Government's handling of the pandemic, saying it "acted in the best way that we were able".[2] CBFJ Cymru does not accept this. Not only does it betray an unwillingness to learn lessons, it flies in the face of the serious misrepresentations outlined above.

Vaccinations

68. Paragraph 32(k) above references the intentional decision, on 25 November 2020, to delay the provision of the Pfizer vaccine to care home residents. This was an incredibly dangerous decision that requires very careful scrutiny in Wales.

69. This decision was contrary to the explicit recommendation of the Joint Committee on Vaccines and Immunisation (JCVI) which directed that care home residents were the first priority cohort for the vaccine. The reason that care home residents were the first JCVI priority cohort for vaccination was because of their extreme vulnerability and because vaccination had such pronounced benefit for this group of people. As explained by Professor Wei

[2] Early Covid response in Wales 'inadequate', report finds - BBC News

Shen Lim in his evidence to the UK Covid-19 Inquiry [Module 4/Day 8:89/7-90/6]: "*the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age care home, we would protect one life. The same number needed to vaccinate to prevent one person from dying in a 65-year old cohort was 1,000, and of the number needed to vaccinate -- to prevent one life -- save one life in the 50-plus cohort is 8,000. So by the time we get to children and young people who have no underlying health conditions, then the number needed to vaccinate to prevent one adverse outcome -- clinical outcome, not safety outcome -- is in the many tens of thousands*".

70. One of the justifications for delaying provision of the vaccine to care homes was the difficulty in storing and transporting the Pfizer vaccine. However, the requirement for ultra-low freezer capacity for the Pfizer vaccine was known from at least 25 August 2020 (see the published UK Inquiry document reference INQ000501330_0018 at paragraph 67) and the failure to procure the necessary freezer storage and develop a delivery plan for care homes in the four months to December, given the known risks to life, is inexcusable. All UK nations faced this challenge, but the response of the Welsh Government was by far the least effective.

71. This poor performance was accompanied by the usual spin and false statements that CBFJ Cymru has come to expect of the Welsh Government. In the published witness statement of Mark Drakeford to Module 4, it is stated "*On 18 January 2021, during a BBC Radio 4's Today programme I was asked about the vaccine roll out in Wales and the suggestion that Wales had vaccinated fewer proportion to its population than other nations of the UK. I explained that there was a very marginal difference in the vaccination statistics but in any event, I explained that the supplies of the Pfizer vaccine had to last until the beginning of February and would not be used all at once. I explained that it would be logistically damaging to use the vaccine all in the first week and the sensible thing to do was to vaccinate over the period that we had to vaccinate, so that the system could absorb it. At no time was the Pfizer vaccine withheld. All Health Boards were received doses of Pfizer which*

were successfully deployed in a manner to minimise wastage, which at that time was less than 1%. I committed to vaccinating all four priority groups by the middle of February and this was achieved" (published under reference INQ000474420_0030). This statement is incorrect in two material respects: first, the statement, "*at no time was the Pfizer vaccine withheld*" is not correct, and vaccines were deliberately withheld from care home residents by a decision of the Minister for Health and Social Care, Vaughan Gething, on 25 November 2020; second, the statement, "*I committed to vaccinating all four priority groups by the middle of February and this was achieved*" is also not correct - only 82% of care home residents were vaccinated by 16 February 2021.

72. Given that the case fatality rate among infected unvaccinated elderly care home residents was one in three, and that vaccine effectiveness for this group against death from Covid-19 was established at between 64% and 96% for doses one and two, rising to 97.5% after dose three[3], this represents yet another failure by the Welsh Government to implement an essential safety measure until it was too late to avoid mass fatalities, and shows how little was learned from the awful experiences of Wave 1.

Concerns about a lack of candour and deliberate destruction of information

73. Across all of the UK Inquiry modules, the Welsh Government has failed to open itself up to detailed scrutiny. That such an approach has been adopted towards the Inquiry is completely unacceptable and betrays the Welsh Government's determination to avoid giving open accounts of what went wrong and why. The Public Office Accountability Bill - not yet enacted - will impose a duty on public authorities and public officials to act with candour, transparency and frankness and makes provisions for the enforcement of that duty by public officials in their dealings with inquiries and investigations. The conduct of the Welsh Government at the UK Inquiry provides a good example of why such legislation is necessary.

[3] Duration of vaccine effectiveness against SARS-CoV-2 infection, hospitalisation, and death in residents and staff of long-term care facilities in England (VIVALDI): a prospective cohort study' published in the Lancet in July 2022

74. The Committee will be aware of widespread public concern at the failure of politicians across the UK to disclose their phone records to the UK Inquiry with absurd claims of digital incompetence by way of explanation. The truth, as everyone knows, is that politicians sought to avoid scrutiny of their communications to avoid embarrassment.

75. An example of this practice within Wales occurred on 17 August 2020 when Vaughan Gething, sent an iMessage to a group of people comprised entirely of Welsh Government Ministers that included Lesley Griffiths, Jeremy Miles, Julie James, Jane Hutt, Ken Skates, Rebecca Evans, Hannah Blythyn, Eluned Morgan, and Julie Morgan. The message of Mr Gething indicated that he was deleting the messages of the group because they could be the subject of a Freedom of Information request, as follows, "I'm deleting the messages in this group. They can be captured in an FOI and I think we are all in the right place on the choice being made" (published by the UK Inquiry under reference INQ000479040).

76. On 15 July 2024 Mr Gething provided a further witness statement (published by the UK Inquiry under reference INQ000493685), specifically in relation to the iMessages of 17 August 2020, again supported by a statement of truth, that includes the following statements:

> Para 9. "The iMessages sent by members of the group did not relate to any decisions by the Welsh Government…"
>
> Para 13. "I did not have a practice of regularly deleting messages. I cannot recall any instances when I suggested or deleted messages with other colleagues of the Welsh Government, including Ministers, senior officials or advisers between January 2020 and May 2020."

77. Contrary to these statements there is an abundance of evidence before the UK Inquiry (that can easily be obtained for scrutiny in Wales) to demonstrates that iMessage and WhatsApp was used to conduct Welsh Government business and make decisions, on issues such as schools and Covid-19, scientific advice, Trest Trace and Protect, and Vaccinations, to cite just a small selection.

78. There is also evidence that WhatsApp messages from a "Ministerial WhatsApp" group were deleted by Mr Gething, including individually, and by turning on the disappearing messages function.

79. The destruction by Mr Gething of information that he believed to be subject to the provisions of the Freedom of Information Act 2000, and his encouragement that Ministerial colleagues should do the same, for the purposes of avoiding public access to this information, is a matter of very serious concern and may constitute a breach of the Freedom of Information Act and Ministerial Code.

80. The use of methods of communication such as iMessage and WhatsApp to conduct government business, and the extent to which such communications and decisions are monitored and recorded is a matter of significant public concern, both generally and specifically in relation to the pandemic. And as already mentioned, there is also widespread public concern and scepticism at the failure of many senior members of UK governments to provide the UK Inquiry with their WhatsApp messages.

81. These issues are not examined in the Module 2 report, and again, they need to be a focus of a Welsh Inquiry.

82. Broader concerns of the CBFJC group in relation to levels of candour at the UK Inquiry, include failures by Welsh Government witnesses in Module 4 to reference the decision to delay the vaccination of care home residents contrary to the advice of the JCVI (the significance of which decision is explained above).

83. There was also a similar failure in Module 5 to exhibit (and a potential failure to disclose to the Inquiry) a report of the Surgical Material Testing Laboratory dated 27 February 2020 which evidences a 50% failure rate when date expired FFP3 respirators were tested by the Welsh Government, the subsequent use of which placed healthcare workers and patients at serious risk (referenced above at paragraph 53). No detailed scrutiny of this important issue was possible at the UK Inquiry because this highly relevant document was not brought to the attention of the Inquiry by the Welsh Government, as it should have been. Further, it appears that this document has not even been disclosed

to the Inquiry (CBFJ Cymru was required to separately source a copy of the report, which is annexed to this statement at annex 3).

84. Other areas of concern from Module 5 are the absence of disclosed documents in connection with the oral evidence of Jonathan Irvine that the out-of-date PPE stock was regularly reported to and known by the Welsh Government (referred to in the published transcript of the oral evidence of the witness Irvine in Module 5, Day 14, Page111, Lines 1-24). Also the absence of minutes from the important Welsh Government Covid-19 Health Countermeasures Group, which operated from at least 02 February 2020 and met weekly, but for which there are almost no formal records.

<u>The adequacy of decisions and actions taken following the peak of wave 1 to prepare for and reduce infections and fatalities in wave 2</u>

85. The most significant criticism of the Welsh Government within the UK Inquiry's Module 2 report is contained at paragraph 6.171 as follows,

> "*From August to December 2020 Wales had the highest age-standardised mortality rate of the four nations. It is* ***likely*** *[emphasis added] that a combination of failed local restrictions, a firebreak that was too late and the decision to relax measures too quickly all contributed to the higher mortality rate.*"

The reason for emphasising the word "likely" is because families in Wales who were bereaved in the second wave need definitive answers as to why this was allowed to happen, and why the lessons of the first wave were not heeded. Bereaved families need something more than likelihood. A detailed causal analysis is required and this can only take place in Wales on behalf of the Welsh public

86. The extent of the problem in Wales is made clear within the Module 2 report at figure 17 (page 267) which demonstrates that Covid-19 deaths in Wales over this period (measured in daily deaths per 100,000 population) were significantly higher than other UK countries (and approximately twice that of Scotland).

87. In this regard, we suggest that comparisons with Scotland are a much better barometer, given their similarities of population, geography, and demographic, than with England. And again, we stress that Scotland has the benefit of their own national Inquiry, which Wales (while performing worse) currently does not.

88. The position is confirmed by the Welsh CMO who in early December 2020 commented that, "the position is dire; visibly worse than the other UK nations" (paragraph 7.15 of the Module 2 report).

89. CBFJ Cymru acknowledges that the UK Inquiry did ask questions of the Welsh Government about devolved matters. However, the Welsh specific scrutiny provided was only at a high-level.

90. Further, the UK Inquiry's Module 1 and 2 reports make clear that its main focus is on the UK Government with devolved governments not receiving the same level of scrutiny, often treated as exceptions and not of equal standing.

91. While the UK Inquiry is described as a four nations Inquiry, it has not undertaken equal analysis of the position in each of the four countries.

92. The position of CBFJ Cymru is that the UK Inquiry has opened the door, but that it will be for a Welsh Inquiry to walk through it. The reasons why the death rate in Wales was so high during the second wave is not fully explored by the UK Inquiry in the Module 2 report, and a detailed causal analysis is required to fully examine Welsh decision-making and operational failures, and to provide accountability and closure.

93. Issues requiring detailed analysis include, but are not limited to, the following:

    a. failures to recognise the risks of asymptomatic and aerosol transmission;
    b. delays in implementing routine testing;
    c. delays in mandating public masking (the last to do so across the UK)
    d. inadequate PPE and IPC;
    e. the delayed firebreak;

f. opening up too soon in circumstances that the evidence did not support doing so;
g. the decision in November 2020 to delay the provision of vaccinations to people in care homes (those in most need);
h. the U-turn in December 2020 to allow positive testing hospital patients to be discharged to care homes;
i. the failure to ensure routine lateral flow testing in hospital and care home settings from December 2020 (to reduce nosocomial transmission);
j. whether claims by the Welsh Government that they adopted a cautious approach are borne out by the evidence and outcomes.

Care homes

94. The treatment of care home residents and their families during the pandemic provides a microcosm of everything that was wrong with the pandemic response in Wales (lack of PPE, lack of testing, inadequate estates and ventilation, ignorance and then misrepresentation of science, and a complete failure to learn the lessons of wave 1) and resulted in many elderly and vulnerable people suffering lonely avoidable deaths, in unnecessary pain without appropriate medical treatment.

95. The Older People's Commissioner for Wales became so concerned at the Welsh Government's pandemic response in care homes that she took the extraordinary step of referring them to the Equality and Human Rights Commission for investigation (see paragraph 65 of the written statement of Helena Herklots published by the UK Inquiry under reference INQ000514106). The Commission investigated Welsh Government decision making around care home residents and in its October 2020 report[4] found that "*a number of decisions in the Covid-19 response may have resulted in failures to adequately protect the right to life, including decisions about hospital discharges, admissions to care homes, prioritisation of testing and access to necessary*

[4] Equality and human rights in residential care in Wales during coronavirus (20 October 2020) | EHRC

healthcare and treatment. Representative groups have described how the combination of decisions in the pandemic response either ignored care home residents or treated them as expendable" (paragraph 32).

96. A letter from March 2020 to vulnerable patients in Wales (publicly referenced in both the opening oral statements of Counsel to the Inquiry and CBFJ Cymru to Module 6) advised them that it was unlikely that they would be offered hospital admission, that they certainly would not be offered a ventilator bed, and they were encouraged to complete a DNACPR so that, "your friends and family will know not to call 999" and so that "scarce ambulance resources can be targeted to the young and fit". Incredibly this letter is an accurate reflection of what happened to many elderly and vulnerable people in care homes. The letter promised, "we will not abandon you" but abandonment was exactly what was being communicated and it raises the question: how on earth were elderly and vulnerable people in Wales considered expendable in this way?

97. The CBFJ Cymru member and former care home owner during the pandemic, Louise Hough, wrote to the Welsh Government on 4 May 2020 to express her outrage at this approach (published by the UK Inquiry as INQ000598472) in which she stated, "*I do hope, when this is over, this is all thoroughly investigated, because I and many other Managers will be stating what a diabolical shambles this is in Wales, and possibly causing many unnecessary deaths*…".

98. CBFJ Cymru hope that it goes without saying that these matters are of such seriousness and concern that they require very careful and detailed scrutiny in Wales.

Conclusion

99. The anger felt by bereaved families in Wales is not just rooted in the loss of their loved ones, but in the Welsh Government's refusal to accept their mistakes, and in the ineffectiveness of the Welsh organisations tasked to protect the people of Wales, particularly the elderly and vulnerable.

100. There needs to be urgent Welsh specific scrutiny in Wales so that there can be learning and improvement.

101. The Welsh Government also needs to take responsibility for what went wrong (which it has yet to do) so that the many thousands of bereaved families can begin to move on.

102. Also annexed to this statement (at annexes 4-11 inclusive) are the Closing Written Statements of CBFJ Cymru in the UK Inquiry Modules to which CBFJ Cymru is a core participant (Modules, 1, 2, 2B, 3, 4, 5, 6, and 7), all of which are published on the UK Inquiry website (and publicly available) and which contain many of the supporting evidence for the statements made within this written statement.

103. It is appreciated that this is a large volume of information and that the Committee members are unlikely to have the capacity to consider them in detail. However, they are provided as reference material and to demonstrate the consistency of the CBFJ Cymru group in seeking to highlight the failures of the Welsh Government during the pandemic, at the UK Inquiry, and also to demonstrate the necessity and importance of Welsh specific scrutiny of these issues.

104. The absence of detailed consideration of Welsh specific issues at the UK Inquiry has placed a real burden on CBFJ Cymru to drive Wales-specific scrutiny, through the proposed questioning of witnesses, including of experts, detailed written submissions, and opening and closing statements. While exhausting and at times re-traumatising, we have carried out this role because we believe it to be essential. However, we have been disappointed at the outcomes at the UK Inquiry which is why we continue to press for a Welsh Inquiry.

105. A particular area of concern is in relation to the expert evidence provided to the UK Inquiry which has contained little separate consideration of the position in Wales - often silent on Welsh issues, or else making assumptions that data and circumstances in England apply equally to Wales, despite Health being a devolved issue. It has become demoralising to CBFJ Cymru members

to have to repeatedly request Welsh inclusion within the expert evidence, with such requests making little or no difference.

106. This is contrary to the assurances provided by the then First Minister, Mark Drakeford, in August 2021 that the UK Inquiry would provide a full and coherent account of the pandemic as experienced in Wales and that if the UK Inquiry proved to be inadequate, then consideration would be given to the commissioning of a Welsh Inquiry.[5]

107. It is also contrary to the expectations of the former First Minister when agreeing to the UK Inquiry, as set out in a letter of 10 September 2021 to Michael Gove (annexed at annex 12), that states:

> *"I want to be very clear that the Welsh Government's decisions – and those taken by other relevant bodies in Wales – should be scrutinised in a very full and comprehensive manner. I do not want Wales to be an after-thought or footnote to the UK inquiry. For the UK inquiry to have credibility in Wales, where there are currently many calls for a separate Welsh inquiry, it is important it proceeds in a way which allows it to focus discretely on Wales as part of its remit."*

108. CBFJ Cymru's position is that it is now abundantly clear from the UK Inquiry reports in Modules 1 and 2 that this necessary Welsh specific scrutiny can only be provided by a Welsh Inquiry focused exclusively on Welsh issues, and we mean no disrespect in asking the Committee to make this recommendation.

Covid-19 Bereaved Families for Justice Cymru
02 December 2025

[5] Drakeford: Welsh Gov could 'reconsider' on holding a Wales-specific Covid inquiry

Schedule of Annexes

1. National Nosocomial COVID-19 Programme Interim Learning Report, March 2023
2. National Nosocomial COVID-19 Programme End of Programme Learning Report, August 2024
3. Surgical Material Testing Laboratory Report - February 2020
4. Closing Written Statement in Module 1
5. Closing Written Statement in Module 2
6. Closing Written Statement in Module 2B
7. Closing Written Statement in Module 3
8. Closing Written Statement in Module 4
9. Closing Written Statement in Module 5
10. Closing Written Statement in Module 6
11. Closing Written Statement in Module 7
12. Letter of the former First Minister, Mark Drakeford, dated 10 September 2021

Easy Read

GIG CYMRU NHS WALES

Interim Learning Report

National Nosocomial COVID-19 Programme

March 2023

How to use this document

This is an easy read document. But you may still need support to read it. Ask someone you know to help you.

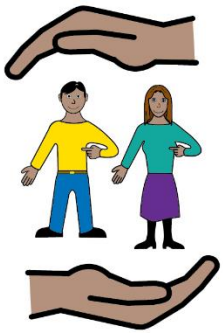
Words in **bold blue writing** may be hard to understand. You can check what the words mean on page 9.

Where the document says **we**, this means **NHS Wales**.

Contents

Background

The pandemic had a big impact all over the world.



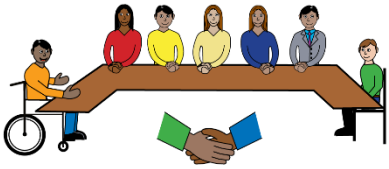
Healthcare had to quickly change to try and keep people as safe as possible.

COVID-19 was a new virus and we did not know much about it. This made it difficult to stop it spreading.

Lots of people caught COVID-19 in the community and in hospitals.

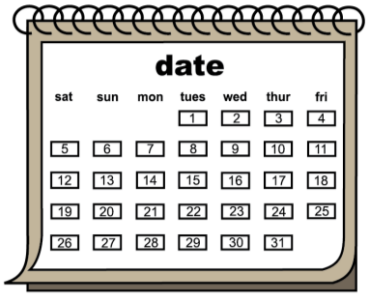
When people catch COVID-19 in hospitals this is called **nosocomial COVID-19**. Sometimes when this happens it may need to be **investigated**.

What is the National Nosocomial COVID-19 Programme?

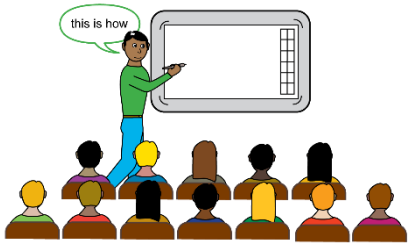


A programme has been set up to help NHS Wales organisations with investigations into cases where COVID-19 might have been caught in hospitals.

The investigations aim to provide answers to patients and families about how they might have caught COVID-19.

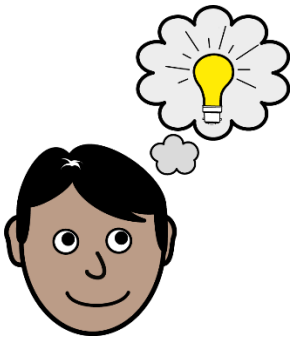


The investigations in the programme cover cases that happened between March 2020 and April 2022. Cases after these dates will still be reviewed/investigated by NHS Wales organisations as usual.

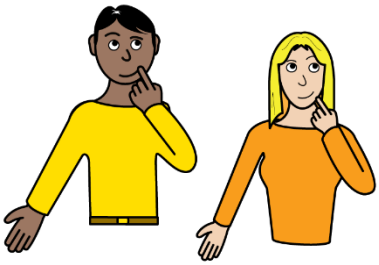


The programme investigations also aim to help the NHS learn and improve.

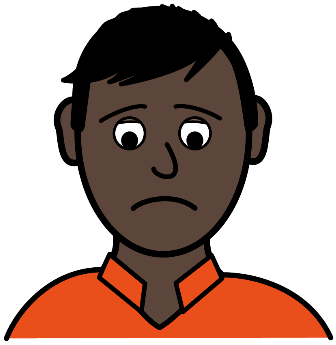
What we learned



What we learned has been broken down into key topics.

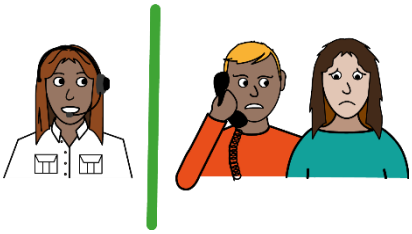


We have looked at people's experiences of care.

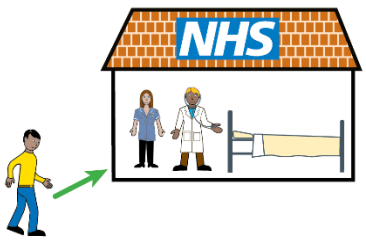


We learned that people who had lost family members were not always offered **bereavement support** as soon as possible.

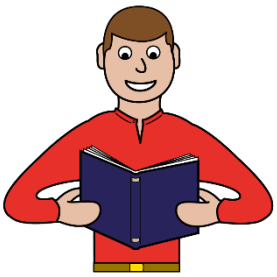
NHS Wales organisations are making lots of changes to offer support earlier.



People also thought having a **single contact** to go to when going through a **concerns process** is very helpful.



Hospital visiting restrictions had a big impact on patients, families and carers. Visitors are a big support with patient care. NHS Wales will remember this, especially the value of carers.



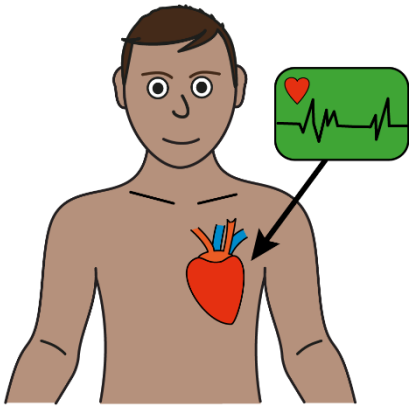
We have also looked at **patient safety incidents** and **concerns**, particularly some of ways we do things.

We learned that people who get sent for care outside of the NHS (such as a care home) do not always know that they have different rights when they have a concern.

Guidance has been updated to help NHS Wales improve.

When people catch infections in hospitals they are sometimes reported in different ways.

Updates have been made to the way infections are reported.



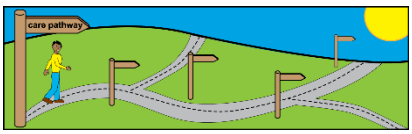
Sometimes a decision is made to not revive a patient using **CPR**. Families like to be involved in discussions where possible.

We are working with staff to help improve communication with families.

We have also looked at **infection prevention and control guidance**. This is the steps we take to reduce the spread of infections in hospitals.

As we learned more about COVID-19, guidance to keep people as safe as possible in hospitals changed quickly. This was difficult to communicate with busy staff.

In future we should think about how quickly we update guidance. We should also continue to improve how we communicate with staff.

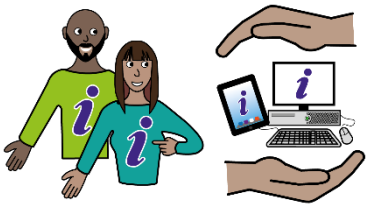


Hospitals were organised into zones to help reduce the spread of COVID-19. Sometimes people were moved lots of times and families were not told.

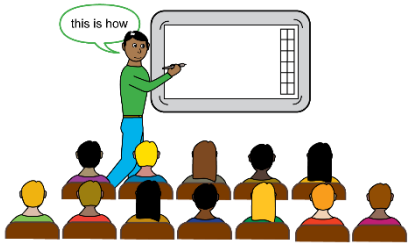
There is now better communication with families when patients are moved.

More information on what we have learned can be found in the full Interim Learning Report. You may want to ask someone you know to read it with you and talk about it.

What we do next



We still have lots of investigations to do over the next year.



We will also continue to share what we have learned across the NHS in Wales.

In Spring 2024 we will share another report about what we have learned and what we have done.

Please contact us if you would like to discuss the contents of this report:

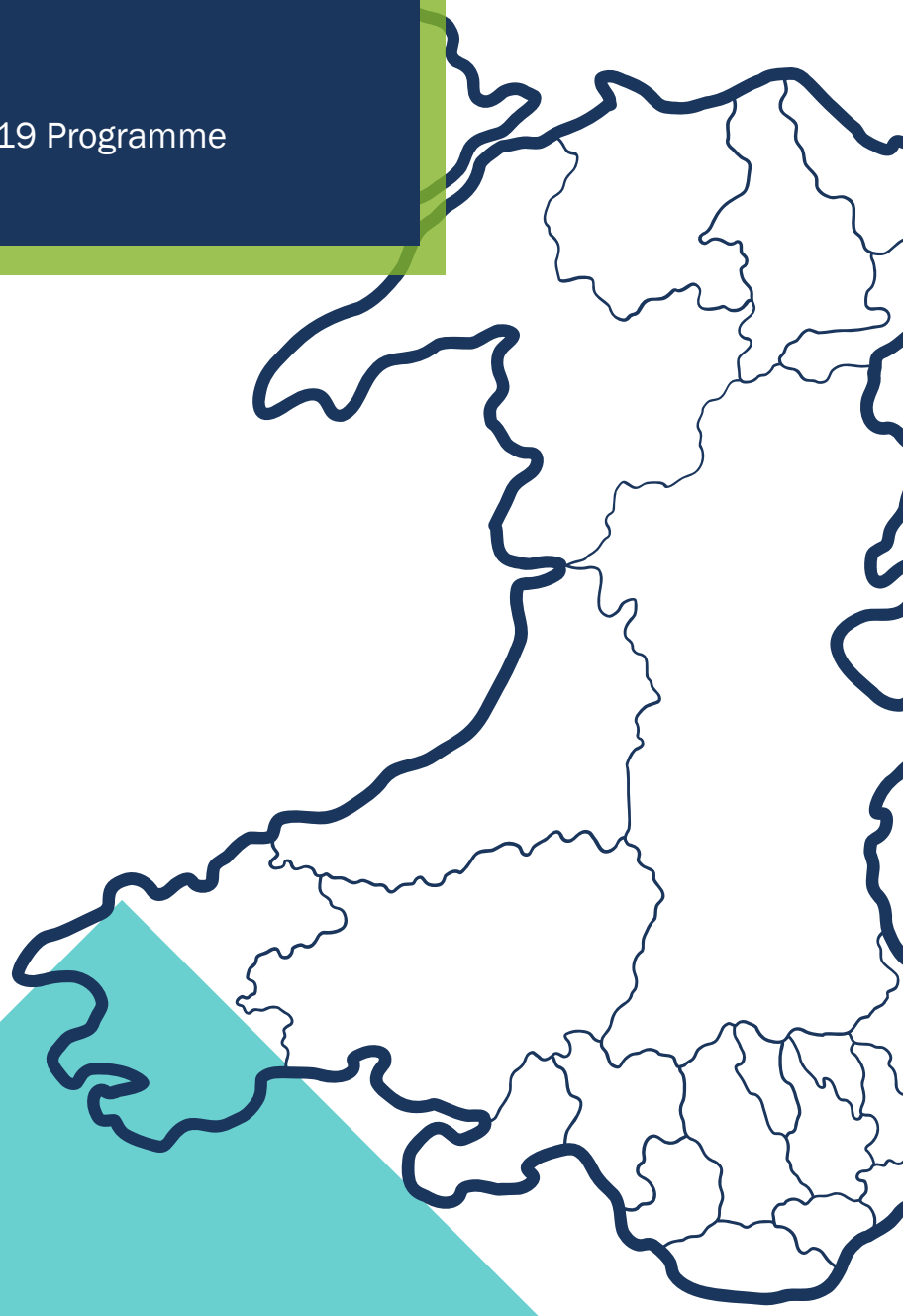
Telephone: 01656 776910
Email: NNCP.Enquiries@wales.nhs.uk
Address: National Nosocomial COVID-19 Programme, NHS Wales Executive (Unit 1), Bocam Park, Bridgend, CF35 5 LJ.

Hard words

NHS Wales	This is made up of local Health Boards and Trusts.
Nosocomial COVID-19	COVID-19 caught in hospital.
Investigated	Looking at facts and feedback to try and find out what happened.
Bereavement support	Support after someone dies.
Single contact	A person or team that can help you.
Concerns process	The process for dealing with complaints.
Patient safety incidents	This is when a patient may have been harmed.
Concerns	When someone is unhappy with care provided.
CPR (Cardio-Pulmonary Resuscitation)	A technique used when someone stops breathing or their heart stops.
Infection prevention and control guidance	Ways to reduce the chances of infections spreading. Examples include face coverings, hand washing and social distancing.

End of Programme Learning Report

National Nosocomial COVID-19 Programme



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Bwrdd Iechyd Prifysgol Cardiff and Vale University Health Board

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Bwrdd Iechyd Addysgu Powys Powys Teaching Health Board

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Contents

1. Introduction

The National Nosocomial COVID-19 Programme (NNCP) wishes to extend its sincere condolences to those who lost loved ones after acquiring COVID-19 in healthcare settings. It has been an extremely difficult time for many families, carers and staff alike and the impact cannot be underestimated.

The purpose of the *End of Programme Learning Report* is to summarise the national learning that has emerged from nosocomial (healthcare-acquired) COVID-19 investigations and the wider programme of work. This report builds upon early learning themes identified in an *Interim Learning Report* which was published in March 2023.

It is important to recognise that the programme is not a nationally led investigation into nosocomial COVID-19 in Wales, nor does it seek to detract from the role of the UK COVID-19 Inquiry. The NNCP was established to support NHS Wales organisations undertake their duty to investigate patient safety incidents in a proportionate way - whilst reflecting the complexities of COVID-19 which caused unusually high numbers of incidents.

2. Background

In response to the pandemic, NHS Wales rapidly adapted and altered its operational focus to minimise the harmful impact of COVID-19 as far as possible, at a time of high levels of uncertainty and anxiety. It is widely acknowledged that NHS staff worked tirelessly through the most challenging period in the history of the NHS to maintain high standards of clinical care and minimise risk to patients. Despite best efforts, the requirement for the NHS to shift operational focus to respond to the pandemic severely disrupted routine healthcare activity.

On an international level, COVID-19 was a new and unpredictable infection of which little was known, beyond the fact it posed a serious threat to global population health.

Whilst infection prevention and control (IP&C) measures are routine practice for the NHS, the spread of COVID-19 in healthcare settings proved challenging, particularly at times when community prevalence was high, and hospitals had significantly high levels of patient complexity, demand and occupancy.

The scale of the pandemic meant that, despite being in a healthcare environment, patients in hospitals and other in-patient settings inevitably faced an increased risk of contracting nosocomial COVID-19. Whilst Health Care Acquired Infections (HCAIs) - now including COVID-19 - are a recognised risk in healthcare settings, developing our understanding of how to investigate matters of patient safety is important to help inform learning and improvement.

3. What is the National Nosocomial COVID-19 Programme?

The NNCP was established in April 2022 to support NHS Wales organisations to conduct proportionate investigations into patient safety incidents of nosocomial COVID-19, which occurred between March 2020 and April 2022. It is a collective membership of all NHS organisations across Wales, working together to implement as consistent an approach as feasible, to investigate nosocomial patient safety incidents.

Beyond the commitment by NHS Wales to investigate and answer as many questions as possible, the programme also provided an opportunity to consider how NHS Wales manages and undertakes patient safety investigations; particularly how service users, families and carers are supported and engaged in the process.

All NHS Wales organisations have a duty to manage and proportionately investigate patient safety incidents in line with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and NHS Wales The Duty of Candour Procedure (Wales) Regulations 2023.

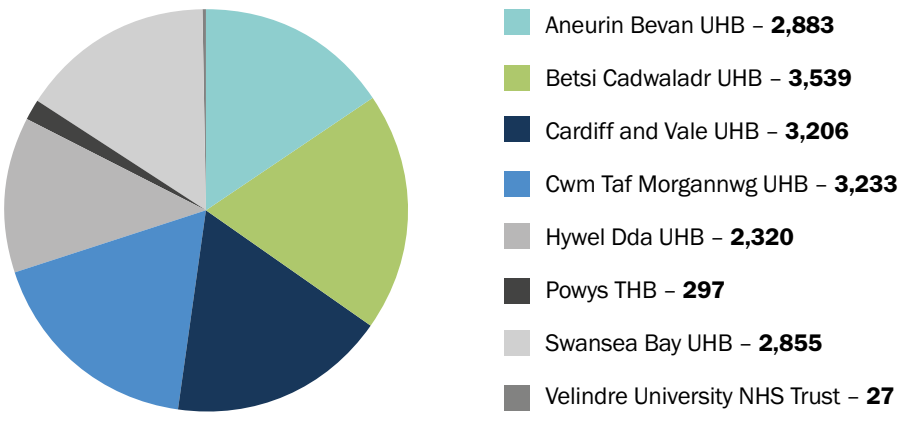
Patient safety incidents are any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care. HCAIs, including COVID-19, will in certain circumstances be considered a patient safety incident, depending on how and when the infection was acquired.

To assist NHS organisations investigating patient safety incidents of nosocomial COVID-19, a *National Framework for the Management of Patient Safety Incidents Following Nosocomial Transmission of COVID-19* was developed, to ensure as consistent an approach as feasible was followed and investigations were done once and done well.

Over the course of the two-year programme, the framework has supported NHS Wales organisations to assess and investigate a total of 18,360 cases of nosocomial COVID-19 where they met the definition of a patient safety incident.

Acknowledging the impact of COVID-19 on service users, families, carers and NHS Wales staff, the programme adopted a learning approach that seeks not to place blame but maximise the opportunity for learning and improvement.

Total number of nosocomial COVID-19 cases investigated by each health board/trust that occurred between March 2020 and April 2022



4. How has learning been identified?

Learning has been identified through various quantitative and qualitative methods including investigation findings, the experiences of people (service users, families, carers and NHS Wales staff), incidental findings, and through collaboration with internal and external partners. Learning has also emerged through organisational scrutiny panels, which are conducted independently of investigations.

Combined learning from across organisations has been collated into national themes to further support the identification of areas for improvement in the quality and safety of services, enhancing provision and people experience. Learning sources include:

- Set-up of the programme including preparatory work
- Test sample audit and subsequent impact assessment
- Investigations
- People's experiences (Service users, families, carers and NHS Wales staff)
- Wider feedback and stakeholder engagement

5. Learning from the programme

5.1 People's experiences

5.1.1 Bereavement support and care-after-death services

Access to high-quality bereavement and care-after-death support services can be extremely helpful in managing grief. When the NNCP was established, consideration was made about how service users - particularly the bereaved - would be supported. A differentiation in pathways for signposting, referrals to, and accessing bereavement support services was identified across NHS Wales organisations. Some NHS Wales organisations did not have dedicated services that offered support following a bereavement.

To help reduce variation in accessing bereavement support, a National Framework for the Delivery of Bereavement Care was launched in 2021. The framework highlighted the need for a consistent and equitable approach across Wales for accessing bereavement support. This has resulted in organisations now having dedicated bereavement support services.

NHS Wales recognised that support should be available for all families contacted as part of the programme and worked collaboratively with health boards and trusts to ensure bereavement support arrangements were in place for bereaved families when contacted. Learning has identified that this came too late for some families connected with the programme, and that the bereavement process for some families has been adversely impacted.

Key learning

Bereavement support services should be proactively offered to all families who are experiencing grief following the loss of a loved one. This is also an extremely important consideration as part of patient safety incident investigation processes.

Families should be proactively signposted to information about bereavement services at the earliest opportunity.

Good practice

The National Framework for the Delivery of Bereavement Care sets out how Wales can respond to those who are facing, or have experienced, a bereavement. It includes core principles, minimum bereavement care standards and a range of actions to support regional and local planning.

Work is taking place with local health boards and a number of partners to develop a national bereavement pathway for Wales, providing information and guidance to health boards, and everyone involved in bereavement support provision, to promote a consistent approach for accessing bereavement support across Wales.

A qualitative bereavement measure within the NHS Performance Management Framework with effect from 2023/24 relates to organisations' progress to embed the National Framework for the Delivery of Bereavement Care in Wales and the National Bereavement Care Pathway.

5.1.2 Supporting service users during an investigation process

Navigating and understanding the concerns process and knowing who to contact with a question is sometimes the difference between understanding and trusting the process, or dissatisfaction and lack of trust. In equal measure, listening to the experience of service users, families and carers is a fundamental principle of good concerns management, and key to ensuring learning opportunities are maximised.

Through contact relating to patient safety investigations, feedback has identified that service users, families and carers found it confusing knowing who to contact and how to discuss a concern or seek clarification on the progress of their case.

To improve this experience, organisations established a dedicated five-day single point of contact for service users, families and carers, when managing a concern.

In April 2023, the Duty of Candour was introduced in Wales as a legal requirement for NHS Wales organisations – requiring them to be open and transparent with patients and service users when they experience harm whilst receiving health care. NHS Wales organisations are required to talk to service users about incidents and involve them in the investigation process.

The duty builds upon Putting Things Right guidance, the process through which concerns and complains are investigated, providing an easy-to-access way of raising complaints and concerns. This was introduced to support the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Over the past 12 years, there have been significant changes in the way people live, work and access healthcare, including additional demands on the NHS in Wales. In 2024, Welsh Government has engaged in an open consultation in relation to the revision of Putting Things Right arrangements, the purpose of this is to place patients at the heart of the process and to ensure they feel listened to. The consultation closed in May and Welsh Government is evaluating the findings.

Key learning

Every service user, family and carer should have timely access to a dedicated and easy-to-access single point of contact to provide feedback, and raise questions, concerns or queries. This is particularly key for patients and families involved in the concerns process.

Supporting information should be available and easily accessible to assist families in understanding the sometimes-complicated language linked to the concerns process.

Good practice

To ensure the principles of the Duty of Candour were enabled for service users, families and carers, a set of minimum standards were established for how services should engage people. The provision supports a coordinated approach to handling queries about nosocomial COVID-19, with ease of access to address additional queries or broader concerns regarding nosocomial COVID-19.

The NNCP has engaged NHS Wales organisations to co-ordinate a pilot of one of the first national surveys that spans all health board and trust areas. Surveys have been developed to gather experiential feedback from patients, carers, and families who have been involved in the investigation process. The pilot which has been tested with a small sample size has demonstrated how CIVICA could have further value if applied to investigation processes more broadly.

5.1.3 Visiting restrictions

Visitors play an important part in a patient's recovery, with evidence continually highlighting the positive role visitors have on outcomes, such as shorter stays and faster recovery times for patients. It is recognised that families and carers are often best placed to observe deterioration and identify a loved one's needs.

Visiting restrictions are a method used in response to infectious outbreaks in healthcare settings. Restrictions during COVID-19 were introduced to help reduce transmission from community settings into hospital environments, and particularly to minimise the risk for vulnerable patient groups.

The programme identified, through service user, family and carer feedback, that visiting restrictions had many adverse effects on the physical and mental health of patients - especially those in the vulnerable groups that the restrictions were intended to safeguard, many of whom were not able to fully understand the decisions made. The limited alternative arrangements for making contact and communicating with loved ones, also negatively impacted the experience for many other service users, families and carers.

Investigations highlighted that families often relied on clinical teams and ward staff to connect with their loved ones. Whilst this communication in the main has been highlighted as positive, there are instances where communication was below the expected standards, especially the inability to make contact during busy periods.

Key learning

All services and wards should have named dedicated patient support teams and volunteers to support families and carers who may be finding it difficult to visit a loved one in hospital.

Future visiting guidance should pay particular reference to the role carers have as an important part of a patient's care team. Health boards and trusts are now further recognising this in scenarios where visiting restrictions need to be implemented.

Good practice

Organisations developed many innovative ways to minimise the impact of visiting restrictions, including virtual visiting via tablet devices, outdoor visiting and utilising ward-based patient support teams to bridge the gap. Organisations continue to use these methods to support contact.

Volunteers also played a key role in bridging the gap, particularly later in the pandemic. Many organisations have continued to strengthen these services and enhanced staff training.

Using learning from the pandemic and other patient experience measures, an NHS Wales People Experience Framework is being developed to support best practice in measuring experience and using insights to inform improvements.

Recognising the value of carers in patient care, revised national visiting guidance now advises that carers should not be classed as visitors and should have an individualised attendance plan with the appropriate clinical area.

With support of Improvement Cymru, the Institute for Healthcare Improvement and their own improvement functions as part of the Safe Care Collaborative, teams at two health boards have collaborated to pilot Call 4 Concern services. The patient safety initiative, which helps to address family/visitor concerns about patient deterioration, provides an extra level of vigilance and timely clinical review.

5.1.4 Communication with families and carers

The involvement of families and carers in patient care is incredibly important. Particularly when loved ones are extremely ill, families and carers can take great comfort in receiving frequent updates and communication from ward teams.

Staff strive to communicate with families and carers often and recognise the extensive value this has. However, in periods of sustained demand and workforce pressures, staff sometimes had to prioritise other patient clinical needs over communication.

It is also worth noting that communication was negatively impacted by visiting restrictions at times, as visiting often offers a useful opportunity to communicate with families and carers.

Through the investigation process, the programme has identified some evidence of poor experience regarding communication around patient updates including; ward movements, notification of positive COVID-19 tests, treatment and discharge planning.

Key learning

The strain placed on ward staff had a negative impact on capacity which had an adverse impact on communication with patients' families and carers.

Under periods of extreme pressure, Patient Advice and Liaison Service (PALS) teams and volunteers, where appropriate, can be effective to support communications whilst ward staff prioritise patient care needs.

Good practice

Patient Advice and Liaison Service (PALS) teams and volunteers had a positive impact on communication with families and carers in the later stages of the pandemic when IP&C restrictions were relaxed. Organisations are continuing to build on how PALS teams and volunteers can provide valuable support to patients and families.

Patient, family and carer feedback, in addition to patient records, have demonstrated examples of good communication which showed a great deal of compassion. This was notable particularly around discharge processes and end of life care.

A health board in Wales has recently embarked on a pilot of new digital communication technology that aims to improve communication with families and carers whilst their loved one is in hospital. The web-based application allows group messages to be sent out by ward staff, which may include updates to ward visiting times or notification of an outbreak on a ward. Personalised messages to individuals about a specific patient will also be a key feature.

5.2 Patient safety incidents and concerns

5.2.1 Patient safety incidents outside of NHS Wales settings

Patients often receive NHS-funded care in other settings, for example, their own homes, care homes, and facilities outside of Wales. Whilst NHS Wales organisations, under the Duty of Candour, have a responsibility to ensure any patient safety incidents that occur to their local population are reported to them, the requirement to undertake investigations can alter.

In applying the National Framework for the Management of Patient Safety Incidents Following Nosocomial Transmission of COVID-19, it has been identified that how the Regulations are applied in different parts of the health and social care system, as well as other sectors such as independent providers (private and public service), is variable and confusing.

Learning has identified that whilst the Regulations require an investigation for concerns relating to the transmission of COVID-19 during NHS-funded healthcare, there are a number of differences when care has been provided by a non-NHS organisation. For example, who undertakes the investigation, how the investigation is progressed, the requirement to compensate and how NHS Wales organisations who fund the care are notified.

The programme identified that the Regulations create variability and inequity for service users, families and carers who receive NHS-funded healthcare via another provider when a concern is raised. On the basis of the Regulations, the current programme does not extend to investigating all instances of nosocomial COVID-19 which occurred through an independent provider setting under NHS-funded care, including care homes.

Evidence from the experience of service users, families and carers connected to the programme to date, suggests they are not routinely informed of these differences.

Key learning

All policies and procedures relating to the management of patient safety incidents which occur during NHS-funded care should set expectations of the standards required across all care settings to minimise confusion for service users, families and carers who may be receiving care across multiple complex care pathways.

Good practice

The learning from applying the National Framework for the Management of Patient Safety Incidents Following Nosocomial Transmission of COVID-19 has been shared with social care colleagues. A good practice guide has been developed for non-NHS support services in other sectors to apply a more consistent and standardised approach to concerns in social care and care home settings.

5.2.2 Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident

Learning from patient safety incidents is an important element to improve quality of care, and continually learn how to minimise the impact of HCAIs and the impact on patients.

Beyond the management of nosocomial COVID-19 as a patient safety incident, learning has identified that current arrangements within NHS Wales for the identification, reporting and investigation of all HCAIs that meet the definition of a patient safety incident are variable.

The programme also identified inconsistent approaches to the management and reporting of HCAIs across Wales and variations in the methodology used to investigate such incidents. It has also been established that the use of surveillance definitions in NHS Wales does not automatically indicate that a patient safety incident has occurred.

A new Health Care Acquired Infection Delivery Board has been established to further coordinate national approaches to learning and improvement across NHS Wales, reducing risks and enhancing practices. The National Policy on Patient Safety Incident Reporting and Management has also been updated to include COVID-19 in line with other HCAIs.

Key learning

All health-acquired infections need to be assessed against the requirement to report as a patient safety incident, in line with national incident policy, and an appropriate patient safety investigation needs to be initiated.

Good practice

As a result of this learning, the national policy on patient safety incident reporting has been updated to reflect new national reporting requirements for HCAIs, including the reporting of nosocomial COVID-19.

5.2.3 The application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

DNACPR is designed to protect people from unnecessary suffering by receiving resuscitation that they do not want, that will not work, or where the harm outweighs the benefits. It is a key enabler in the promotion of a dignified death.

A common theme in the concerns raised by families and carers during the early part of the programme was the application of DNACPR decisions for patients who acquired COVID-19. Some of the themes in the concerns related to a view that there was a 'blanket approach' to applying the decision when somebody was diagnosed with COVID-19, and a lack of knowledge or consultation in the process of applying the decision.

Findings from investigations and other sources such as the Medical Examiners Service and mortality reviews have identified that there was a:

- Need to improve the description of patients' co-morbidities and their impact on the reason for a DNACPR being enacted
- Need to improve communication, especially around the rationale for DNACPR implementation and discussions with patients, families and carers
- Need to improve documentation related to discussions with patients, families and carers
- Need to improve the DNACPR document, particularly whether a decision should be reviewed if a patient's condition improves

Whilst a DNACPR decision does not strictly require consent from a next of kin or carer before application, unless the patient lacks capacity, learning from the investigations has recognised the importance of such communication, and the impact the management of this sensitive subject can have when managed well, and in these instances, not so well.

The analysis did not identify evidence or trends that DNACPR decisions had been placed inappropriately, or not in keeping with the current All Wales DNACPR Policy.

Key learning

Service users, families and carers place great value on good communication around the DNACPR process and need to be involved as much as possible in the decision-making process. Continued development and roll-out of an electronic advanced care planning document, is also seen as key to improvements which would support clinicians during the process and alleviate some of the potential issues around DNACPR documentation and broader communication.

Good practice

There is an NHS Wales Strategic Advance and Future Care Planning Group that includes representatives from NHS organisations. The group has agreed to strengthen the section in the policy relating to appropriate and timely communication with patients and families. This is seen as an important step to support clinicians to move beyond the formal process of DNACPR, providing helpful guidance and support in how, when and with whom to communicate to ensure understanding and minimise upset.

In 2023, the All Wales Competency Framework for Completion of DNACPR was published to support healthcare professionals who are involved in end of life care with patient conversations around DNACPR. This has been shared with health boards and trusts across Wales for implementation.

In line with the All Wales Learning from Mortality Review Framework, NHS Wales organisations have been undertaking local thematic reviews in relation to DNACPR, and a national thematic review has also been carried out. Thematic review is a process that helps organisations understand what happened in multiple cases that underwent further investigation, linked by specific common features, to learn from them and to make changes that will consequently lead to improvements in the safety and quality of service. Following the national thematic review, an action plan has been produced which highlights areas for improvement to be taken forward around topics such as understanding, awareness, communication, training and processes.

5.2.4 Clinical record keeping

Timely and accurate clinical record keeping is essential to communication between healthcare professionals, promoting patient safety, quality of care and effective continuity of care.

Clinical records serve as an important reminder of what care a patient has received, including diagnoses, procedures, consultations, actions and outcomes. They are a critical reference point for healthcare professionals involved in a patient's care to understand the patient's history and treatment plan. In the event the standard of care is ever queried, clinical records evidence the care that was delivered.

Throughout the pandemic it is widely acknowledged that healthcare services faced extreme system pressures which resulted in staff frequently needing to prioritise the immediate clinical needs of patients. As a result, clinical records sometimes did not meet the expected standards.

Investigations through the NNCP have identified legibility and accuracy as an area requiring improvement in some clinical records, often missing detail and rationale, or not recorded in a timely manner. This would likely have presented a challenge to clinical teams delivering care, and prolongs the investigation process into patient safety incidents. At times, poor record keeping can also be attributed to the fact staff were required to self-isolate at home at short notice without access to hard copy clinical notes.

Clinical record is integral to patient safety, investigations demonstrate clinical staff documented key care and treatment information in most cases reviewed. However, there was an absence of detail in some cases and limited information on family communication.

Key learning

For clinical records to be completed to a high standard, clinical staff need the time to focus their attention on record keeping. There may also be wider value in reaffirming to clinical staff the value in record keeping and how it supports the patient safety agenda and investigation processes.

Digital solutions for clinical record keeping support good practice, enhancing legibility and timely access to notes. Work underway by Digital Health and Care Wales and NHS Wales organisations to embed systems such as the online Welsh Nursing Care Record will enhance the quality of record keeping and improve patient safety.

Good practice

In many cases, the standard of clinical record keeping was good and demonstrated the high quality of care delivered, and notably the compassion showed by staff, despite being under unprecedented pressure. In the absence of visiting, many clinical records demonstrated how clinical staff were extremely attentive and went above and beyond to support patients and communicate with families. This was particularly evident around end-of-life care and with critically unwell patients.

Despite some improvements being required around legibility and accuracy of clinical record keeping, there were many excellent examples of clear and concise records, with detailed rationale and information on contact with families and carers.

The Welsh Nursing Care Record (WNCR) launched in April 2021, replacing paper adult inpatient nursing notes with a secure digital system and transforming the way nurses record, store and access information. These digital documents have a standardised nursing language, which improves accuracy and makes it easier to share information between settings. The WNCR is now live in all health boards across Wales and Velindre NHS Trust, and is being used across more than 300 wards. As of April 2024, nearly 13 million inpatient nursing notes have been captured in the system and nearly 21 million digital risk assessments have been completed.

5.2.5 Staffing and resource

One of the most significant challenges throughout the COVID-19 pandemic was maintaining staff provision to deliver safe, high-quality and timely care to patients. Increases in the number of patients in hospital and more severe illness, in conjunction with staff absence (commonly due to COVID-19 and/or the need to self-isolate), placed huge pressure on NHS workforces.

There are national standards in place for healthcare professionals across a number of disciplines and all health service bodies are required to maintain appropriate staffing provision to provide the best care possible to patients.

During the onset of the COVID-19 pandemic, typical ways of working were suspended or altered to ensure health boards and trusts could respond to the risks the pandemic presented.

Many NHS staff were redeployed to areas experiencing increased demand or depleted staffing levels. Many staff were also utilised to support with the vaccination programme and testing. Additionally, a number of hospital wards were repurposed to establish additional capacity based on patient need. The flexibility of staff going to work in different areas should not be underestimated.

Investigations have demonstrated how in periods of huge uncertainty and distress, staff left their familiar working environments in the interest of caring for patients. Despite variations in skill mix, competency and experience, staff rose to the challenge. Findings also highlight how the contributions of new graduates and Health Care Support Workers was instrumental in the delivery of patient care in such intense periods of pressure.

Prior to the pandemic, the NHS in Wales, and the wider UK, has faced challenges with staff recruitment and retention. Investigations reinforce how existing vacancy rates intensified workforce pressures during the pandemic. Health boards and trusts were extremely agile in reviewing capacity and demand and identifying where resource is best placed based on patient need.

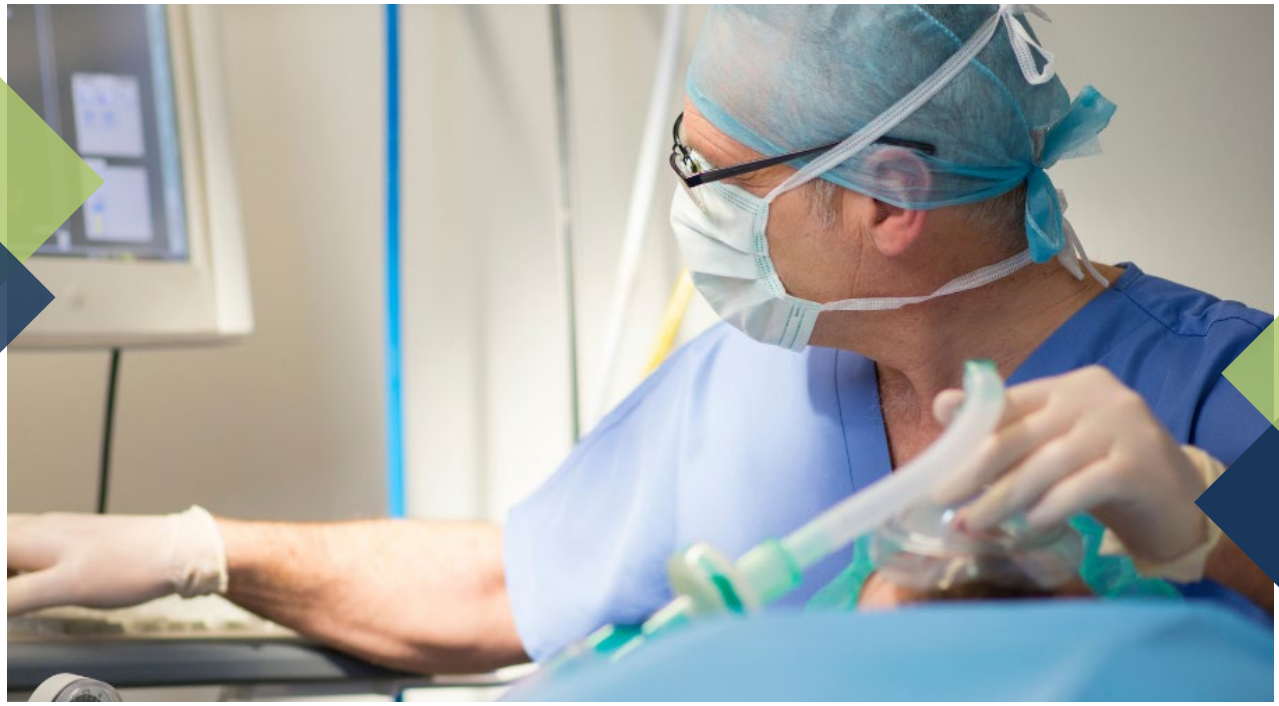
Health boards and trusts utilised agency staff where possible to cover absence and/or enhance resource. Findings suggest agency staff made an extremely valuable contribution as part of the NHS Wales workforce, however, working in unfamiliar environments with different systems and processes sometimes put additional pressure on both NHS employed and agency staff, subsequently impacting quality of care.

Despite best efforts, staffing levels were under significant strain, and at some points, NHS Wales organisations were not able to maintain safe staffing levels.

The unintended consequences of this in conjunction with wider workforce challenges were increased risks to patient safety and sub-optimal care. It should be noted that during these circumstances, it was a distressing time for patients, families, carers and healthcare professionals who constantly strive to uphold the highest standards of care.

'A Healthier Wales: Our Workforce Strategy for Health and Social Care' is a 10 year strategy launched by Health Education and Improvement Wales and Social Care Wales in October 2020 with an ambition of 'A motivated and sustainable health and social care workforce'. The strategy is divided into three phases with work currently underway to develop the implementation plan for phase two. The long-term direction is to ensure there is a sustainable workforce for the future.

In addition, building on this strategic direction, Welsh Government implemented 'The National Workforce Implementation Plan' in January 2023, as a direct consequence of the pandemic where despite record staffing levels, healthcare workers were stretched to capacity. The plan highlights a number of actions that need to be progressed to address some of the most urgent pressures within the NHS, including recruitment and retention.



Key learning

There is extensive value in continuing work to enhance healthcare staffing provision. Recruitment and retention must continue to be a priority across NHS Wales for preparedness and resilience in a future pandemic scenario.

Good practice

NHS Wales staff were extremely agile throughout the pandemic, frequently working in unfamiliar environments in the interest of patient care and service delivery.

Health boards and trusts responded promptly to constantly shifting capacity and demand, in conjunction with quickly fluctuating resource levels. Many organisations responded with dedicated teams to monitor staffing levels and take quick action to maintain them. The way in which whole organisations worked together to utilise resource in the best place had a significant impact on maintaining safe delivery of care.

5.3 Infection prevention and control

5.3.1 Publication and distribution of guidance

National policy and guidance on IP&C are essential elements in supporting healthcare organisations to develop and implement local strategies which help to reduce the risk of infections. In response to the pandemic, the UK infection prevention and control guidance was coproduced across the UK's four nations and was published by the UK Health Security Agency (formerly Public Health England).

Due to the need to respond rapidly to the significant population health risk that COVID-19 posed, guidance updates were published frequently, at short notice and often out of normal business hours. The rapid increase in the prevalence of COVID-19 and the high demand on health and social care, in addition to the emergence of new evidence, made it necessary to update guidance on an almost weekly basis, sometimes more frequently.

NHS Wales staff experience has shown that the frequency in which the guidance was updated, created challenges for already stretched IP&C teams, who are responsible for leading the necessary changes for all HCAIs across often large and complex organisations. Naturally, it can take time to assess and disseminate guidance which requires organisations to make significant adjustments to care delivery. For example, changes to care pathways, guidance on PPE (personal protective equipment), and testing processes.

The expectation that guidance should be implemented immediately, once published, was a significant challenge during the pandemic, particularly given the level of resources required to ensure training, communication and application across large workforce numbers and settings. The implementation impacted staff who worked shifts and/or were off sick, making it difficult to keep pace with changes in guidance that related to their practice.

Whilst acknowledging updates to IP&C policy are critical, the NHS in Wales should consider how updates are distributed and communicated when an evidence base is rapidly evolving in a future pandemic scenario.

Key learning

NHS Wales organisations are encouraged to continue exploring and implementing digital communication methods that support timely and engaging communication with colleagues on updates to guidance.

5.3.2 Outbreak management

Testing is an important mechanism in the identification and prevention of infectious diseases, including COVID-19. Access to appropriate testing and the timely turnaround of test results are crucial to mitigating and preventing the onward spread of infectious diseases.

Increased demand for COVID-19 testing during the pandemic posed a significant challenge to the existing testing infrastructure, which still had to manage routine provisions such as blood tests for in-patients. Demand exceeding capacity and the inability to test rapidly for COVID-19 during periods of 2020, meant that testing was somewhat ineffective as a mechanism for reducing infections, until the supply of consumables met demand and testing capacity increased.

Due to the testing capacity challenges early in the pandemic, patients were discharged into other care settings or their own homes without the ability to rapidly test for COVID-19. This was in line with national guidance at the time, which did not advise that negative tests were required before transfer/admission into residential settings.

Further UK guidance, especially early in the pandemic, actively encouraged the discharge of patients from hospitals into care home settings, to free up hospital capacity in order to manage the anticipated demand for services.

Whilst a testing strategy produced by Welsh Government was launched on 15th July 2020, significant challenges in applying the policy existed due to limited access to the volume of consumable items required to undertake tests, and laboratory capacity to manage the extreme demand. Additional capacity beyond the existing infrastructure was achieved with the launch of the lighthouse laboratory (IP5), towards the end of August 2020, this meant it became easier and quicker to test patients and staff for COVID-19.

As well as testing, isolation plays an important part in preventing and controlling the spread of infections, especially in healthcare settings. Timely testing, along with the ability to isolate suspected or positive patients can aid in preventing onward transmission. It is important to note that isolation is one of several control measures and must be used in conjunction with other measures to be effective.

It should also be noted that isolation for infection purposes brings additional risks to patients with other care needs, particularly for older and vulnerable people, such as falls. Decisions to isolate patients for infectious purposes, even when isolation is available, should be considered in a holistic risk-balanced way that does not introduce the risk of additional harm.

An aged estate and limited isolation facilities (such as access to single rooms) meant that patients were often unable to be isolated, and cohorting was established to maintain operational flow through hospitals during extreme demand. The inability to isolate patients often meant that, in an attempt to reduce spread of infections, service users were subjected to multiple ward movements.

In line with UK guidance, the introduction of designated care pathways, which aimed to prevent onward transmission (as far as reasonably practicable), played a significant part in multiple ward movements - especially in older estates.

Experience from families and carers found that they were often not informed of these movements, which resulted in additional communication difficulties when seeking updates.

Key learning

Policies and processes should reflect mechanisms that result in limiting the number of patient moves, ensuring patients are in the right place at the right time.

Where patients are moved, families should receive proactive and timely communication on the location and rationale for the move.

Good practice

Organisations rapidly implemented increased point-of-care testing to support clinical care delivery and assist in more timely diagnosis and clinical decision-making. This supported improved daily epidemic control by reducing patient movements and achieving early detection for treatment plans to be put in place which assisted in the safe and timely transfer/ discharge of patients into alternative care settings where necessary.

During the pandemic, a health board implemented a patient safety initiative that has since been developed and shared as an example of good practice in forums across Wales. The framework and risk assessment supports clinical teams with guidance to aid decision-making processes for patients with suspected respiratory illnesses, notably COVID-19. The framework is used as a practical tool for new admissions and patient transfers – centred around keeping patients as safe as possible.

5.3.3 Discharge planning

The discharge planning process in healthcare requires a multi-disciplinary approach across health boards and trusts, local authorities and other care providers. Effective discharge planning is crucial to continuity of care as well as having patient safety benefits.

In hospital settings, despite IP&C provision, there is a constant infection risk due to a number of factors. Timely discharge can reduce infection risk (of HCAIs), as well as enhancing the recovery process and improving patient mobility. A planned targeted discharge date and time reduces a patient's length of stay, readmissions, pressures on hospital bed capacity, and services.

During the pandemic, significant volumes of patients were deemed 'medically fit' for discharge, but the discharge process was delayed due to challenges such as, care home closures due to outbreaks or inability to receive COVID-19 positive patients, vulnerable relatives at home, or delays in allocating packages of care. Many services that were considered 'non-essential' were also limited, reduced or ceased, which had a significant impact on patient flow.

Even though delay in discharge was not a 'new' issue during pandemic, it was worsened by the unprecedented pressure placed on the health and social care sectors.

Key learning

Patients who experienced delayed discharge were at an increased risk of deterioration and infection. It should be acknowledged that delayed discharges were arguably a symptom of unprecedented wider system pressures (secondary, primary and community care) including different ways of working, high levels of seriously ill patients, staffing pressures and limited patient movement due to IP&C precautions and national guidance regarding discharge arrangements and community support.

Good practice

Investigations have demonstrated a good multi-disciplinary approach to discharge planning between health boards, trusts, local authorities and other care providers, working collaboratively to discharge patients from hospital settings at the earliest opportunity.

The Safe Care Collaborative has been working with a health board to maximise the number of 'green days' for inpatients - those that positively contribute to patients' rehabilitation journey towards discharge. The project has focused on recognising the value of time for both staff and patients, maximising how the available skills are used for the benefit of patients 24 hours a day. The project has been well-received by staff, who are reporting positive feedback from patients and examples where patients are being discharged more quickly and with greater function as a result of the work.

5.3.4 Hospital environments

Ageing estates across health boards and trusts in Wales present a number of challenges in relation to both IP&C and patient experience. Since many of the hospitals and other healthcare settings across Wales were designed and built, IP&C and patient experience best practice have developed considerably.

Many healthcare settings have limited access to single rooms which means there is less opportunity to isolate patients. As a result, many patients were cohorted to reduce the spread of infection, which often meant patients experienced multiple ward movements.

Bed-spacing and ventilation were also a challenge in some areas which limited the ability to manage the risk of infection. There is room for improvement in the design of future healthcare settings – the pandemic and subsequent learning has highlighted the impact modern estate design, such as the availability of single rooms, can have on strengthening IP&C.

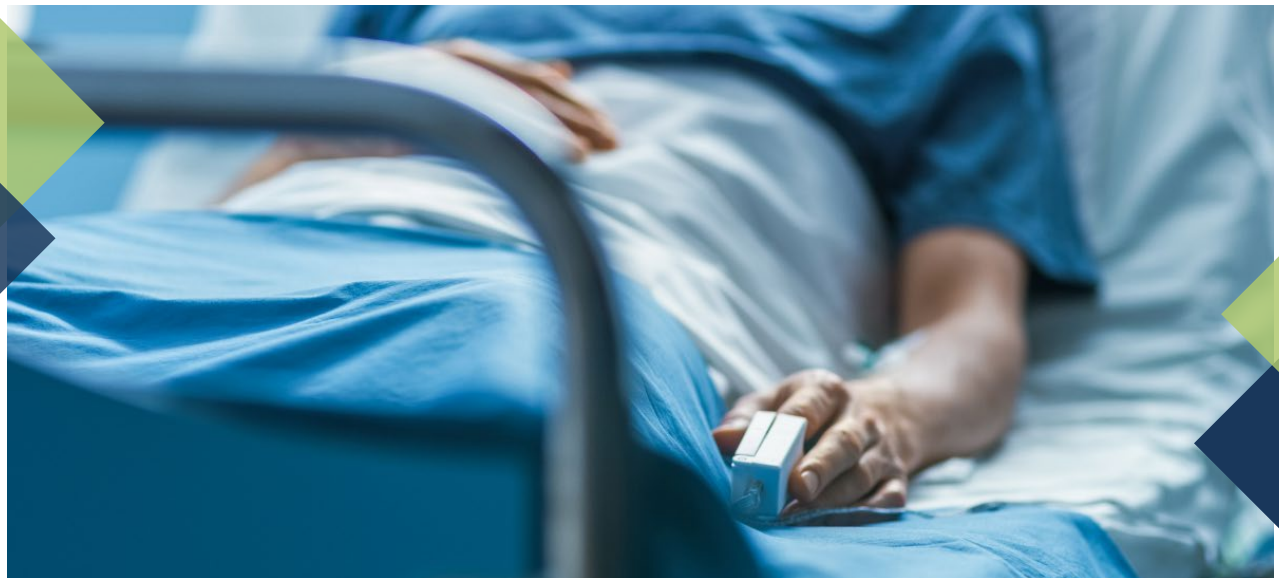
From a patient experience perspective, improved hospital environments provide a more comfortable and safer space to receive treatment. During the pandemic when visiting was reintroduced on a risk-based approach, some patients could not receive visitors due to limited space and the associated increased infection risk. Not receiving visitors had many adverse impacts on patients, as described in the previous 'visiting restrictions' section.

Key learning

An aging healthcare estate in Wales presents a number of challenges, especially around IP&C in a pandemic scenario. Where possible, health boards and trusts should continue make improvements that enhance IP&C measures and use learning from the pandemic to inform future hospital design.

Good practice

Excellent collaborative working between ward teams and IP&C colleagues enabled efficient cohorting of patients and movement based on emerging national guidance and risk assessment.



6. Closing remarks

The COVID-19 pandemic presented one of the most challenging periods in the history of the NHS, with far-reaching impacts. Conducting reviews of nosocomial patient safety incidents has been essential to provide as many answers as possible to patients, families and carers, in addition to identifying learning opportunities that will enhance future care delivery and experiences of healthcare.

National and local learning from investigations has demonstrated examples of sub-standard care and areas for significant improvement, as well as areas of best practice that show examples of adaptability and innovation.

Health boards and trusts in Wales have been sharing learning in a range of forums throughout the programme and learning will continue to be triangulated in the appropriate places to support improvements. Learning from investigations will have a significant impact on experiences, quality of services, and safety of patients and service users receiving care.

The NNCP extends its sincere thanks and gratitude to patients, families, carers and NHS Wales colleagues who have engaged with the programme and investigation process.

7. Additional information

Accessing support

People involved in the programme are encouraged to reach out to their designated health board/trust if they feel like they need a conversation about some of the findings.

Mental health and wellbeing support can be accessed 24/7 via the CALL Mental Health Listening Line, call 0800132737 or text “help” to 81066.

Information about grief and bereavement, and available support, can be found on the NHS 111 Wales bereavement web page.

Access to mental health and wellbeing support for NHS Wales staff is available through wellbeing services and occupational health in each health board/trust in the first instance. Additional mental health and wellbeing support can be accessed through the CALL Mental Health Listening Line.

Glossary of terms

Cohorting	Defines groups of people with shared characteristics from health data being placed together where demand exceeds capacity. In the context of this report, cohorting relates to suspected COVID-19 diagnosis and other health related issues.
Concern	A concern is any patient safety incident, or any expression of dissatisfaction raised by a member of the public and can be verbal or written.
Consumable items	Goods used by individuals and businesses that must be replaced regularly such as needles / swabs etc. In the context of this report, 'consumables' refers to items used for COVID-19 testing.
DNACPR	This refers to a specific process of discussion and documentation NOT to initiate future CPR (Cardio-Pulmonary Resuscitation) in the event of a future cardiac arrest and natural and anticipated dying event. A DNACPR decision does not have repercussions on any other element of treatment and care.
Independent providers	Services delivered by organisations that are not NHS Health Board/ Trust services. Examples include independent care providers such as care homes, local authority social services, charities and Third Sector organisations.
Nosocomial infections	Nosocomial infections, also referred to as 'healthcare-associated infections' (HAI), are infection(s) caught during the process of receiving health care, and where that infection was not present during the time of a person's admission to hospital or healthcare setting. They may occur in different areas of healthcare delivery, such as in hospitals, long-term care facilities, and ambulatory settings. The infection may also appear after discharge from a healthcare setting but are attributed to the time a person was in contact with the healthcare setting.
Patient safety incident	An unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care.
PPE (Personal protective equipment)	Protective face coverings, clothing, helmets, goggles, or other garments, designed to protect the wearer from injury or infection.
Service users	Anybody using NHS Wales healthcare funded services.
Surveillance definitions	Surveillance of Health Care Acquired Infections refers to the monitoring and reporting of these events. Surveillance definitions are used to categorise these events as part of investigations.

Y Gwir Anrh/Rt Hon Mark Drakeford AS/MS
Prif Weinidog Cymru/First Minister of Wales

Llywodraeth Cymru
Welsh Government

Rt Hon Michael Gove MP
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10 September 2021

Dear Michael

UK Covid Inquiry – Wales

Thank you for taking time to meet me in the margins of our joint appearance at the British-Irish Association conference in Oxford, last weekend.

As I explained, I believe a UK-wide Covid inquiry is the best option to properly – and openly – scrutinise the decisions made by the Welsh Government and other public sector organisations in Wales during the pandemic. In my view this will also be the best way in which Wales can learn important lessons for the future.

The Welsh Government and public bodies here have, of course, made decisions for Wales in what we believe were – and are – the best interests of the country. At times our decisions have varied significantly from decisions made elsewhere in the UK. However, the broad context for our decision-making has been inextricably linked to consideration of the wider UK science and policy landscape.

For example, SAGE advice, the UK chief medical officers' network, Treasury and UK Government support measures have all set the parameters within which decisions made in Wales by the Welsh Government have been made.

I want to be very clear that the Welsh Government's decisions – and those taken by other relevant bodies in Wales –should be scrutinised in a very full and comprehensive manner. I do not want Wales to be an after-thought or footnote to the UK inquiry. For the UK inquiry to have credibility in Wales, where there are currently many calls for a separate Welsh inquiry, it is important it proceeds in a way which allows it to focus discretely on Wales as part of its

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remit. This will require visibility – the inquiry team should come to Wales to take evidence, it should have Welsh-specific expertise available to it, and it will be important to produce Welsh chapter/s as part of the report so that citizens here can reflect transparently on the Wales narrative and conclusions.

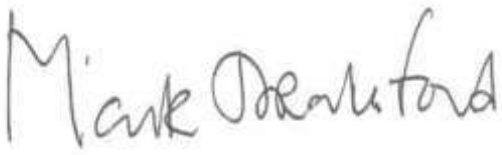
In our discussion you indicated you broadly agree with the position I set out and have distilled here.

The challenge is to ensure that the inquiry's terms of reference, membership, resourcing and methodology is capable of delivering against political and public expectations in Wales. I would strongly advocate a collaborative process between the UK Government and the Welsh Government, and the others nations, of course, in drawing up comprehensive terms of reference and practical remit instructions.

It would be helpful to hear your thoughts on the best way we can work together to take this forward.

I am copying this letter to Sue Gray in the Cabinet Office, who helpfully joined our meeting in Oxford.

Best Wishes



MARK DRAKEFORD

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

CLOSING STATEMENT
ON BEHALF OF COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU
FOR MODULE 1 ('M1')

I. INTRODUCTION

1. These submissions are made on behalf of Covid-19 Bereaved Families for Justice Cymru ('CBFJ Cymru'). They supplement the evidence already provided to the Inquiry by Anna-Louise Marsh-Rees pursuant to r.9 Inquiry Rules[1] and in oral evidence.[2]

2. CBFJ Cymru is a group dedicated solely to campaigning for truth, justice, and accountability for those bereaved by Covid-19 in Wales. CBFJ Cymru is led by Anna-Louise Marsh-Rees, Sam Smith-Higgins and Liz Grant and guided by the concerns of its bereaved members across Wales. CBFJ Cymru is committed to giving a voice to all those in Wales who are bereaved due to Covid-19. Since its establishment, CBFJ Cymru has become the most prominent organisation in Wales in the discourse surrounding Covid-19 and will continue to ensure that there is proper scrutiny of all governmental decision-making relevant to Wales, including decisions made in Westminster and by the Welsh Government.

3. CBFJ Cymru members have experienced first-hand the consequences of the catastrophic failure to adequately prepare for a pandemic in Wales. Its members experienced and continue to experience suffering and trauma due to the devastation caused by Covid-19. They lost loved ones in care homes receiving patients from overwhelmed local NHS Wales hospitals without adequate isolation or protection.[3]

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[1] Witness statement of Anna-Louise Marsh-Rees (INQ000183392)
[2] Transcript 18 July 2023, pp 38-54
[3] The total for all deaths of adult care home residents involving Covid-19 between 2020-2022 is 2,267, according to Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Services-for-Social-Care-and-Childrens-Day-Care/notifications-to-care-inspectorate-wales-related-to-covid-19-in-adult-care-homes/deathsofresidentsfromadultcarehomes-by-dateofnotification-cause

They lost loved ones due to hospital acquired Covid-19 in the context of inadequate infection control and a lack of adequate PPE in Welsh hospitals, many of which were known to have inadequate ventilation. Rates of hospital acquired Covid-19 have remained high in Wales.[4] Many members have professional experience working in sectors heavily impacted by Covid-19 and experienced shocking conditions as workers on the front line. They saw first-hand the failures and deficiencies in the Welsh Government's pandemic preparedness, risk management, and civil emergency planning. Many were simply not provided with the protection that they deserved.[5]

4. CBFJ Cymru's primary aim is to assist this Inquiry to understand why decisions were made by those responsible for pandemic planning in Wales and to understand what went wrong and why. CBFJ Cymru also considers that it is essential that any errors are publicly acknowledged and accepted by the Welsh Government so lessons can truly be learned and so that there can be proper accountability in Wales.

5. On the evidence before the Inquiry in Module 1 there can be no doubt that the Welsh Government and Welsh institutions tasked with protecting people in Wales failed to adequately prepare for a pandemic in Wales. In terms of learning lessons, CBFJ Cymru believes that there needs to be a fundamental change in approach in Wales to preparedness for the next pandemic and a willingness to be candid about what went wrong and why. If this does not happen Wales will not be prepared and more people in Wales will lose their lives.

6. CBFJ Cymru commends the inclusion by the Inquiry in Module 1 of the oral evidence of representatives of the bereaved family groups. CBFJ Cymru considers that hearing directly from bereaved family members is vital to ensuring that the impact of Covid-19 in Wales is fully understood and to ensure that the significance and magnitude of the issues under investigation in the Inquiry are not lost. The bereaved must remain at the heart of this Inquiry. Hearing directly from the bereaved is crucial to ensure that this continues to happen as the Inquiry moves into later modules.[6]

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[4] https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/ (See: Headline Summary)
[5] Wales Online - https://www.walesonline.co.uk/news/health/coronavirus-nhs-staff-deaths-covid-19409143
[6] Transcript 4 October 2022 p 6

7. The following submissions are aimed to assist the Inquiry's consideration of its findings: the factual narrative and lessons to be learned in Module 1.

II. SUBMISSIONS

8. CBFJ Cymru submits that the following high-level findings are supported by the evidence before the Inquiry in Module 1 and relevant to Wales:

    a. Pandemic planning in Wales was the responsibility of the Welsh Government in the relevant period;
    b. Pandemic planning, preparedness and resilience in Wales was wholly inadequate, including in relation to:
        i. flawed planning assumptions;
        ii. resourcing for infection prevention and control, and segregation measures in Welsh hospitals;
        iii. infrastructure of the NHS Wales estate;
        iv. failure to stockpile Respiratory Protective Equipment ('RPE')/PPE and ensure distribution networks;
        v. inadequate planning in relation to post-death procedures to protect dignity and to support the Welsh bereaved in the event of a pandemic;
        vi. inadequate oversight and assurance as to implementation of preparedness;
    c. The Welsh Government and their advisers had sufficient notice, knowledge, and warning of the risks to the lives of people in Wales from a pandemic (including SARS) but failed to take adequate steps to prepare and build resilience.

9. The submissions will address: (i) Responsibility for pandemic preparedness (ii) Flawed planning assumptions (iii) Welsh Government risk registers (iv) Ministerial engagement in pandemic risk (v) Fragmentation in the pandemic preparedness system (vi) Deficits in planning, testing and acting on the lessons of exercises (vii) Extent of implementation of preparedness – infection, prevention and control (viii) PPE (ix) Inequalities (x) Intergovernmental communications (xi) Access to scientific advice (xii) Lessons learned.

Pandemic preparedness: responsibility

10. The Welsh Government has at all relevant times had responsibility for pandemic planning and preparedness and has had powers to undertake pandemic planning. Health and social care were devolved to the Welsh Government in 1999 following the Government of Wales Act 1998. Subsequently, the administrative organs of Wales were and remain responsible for their decisions in respect of those areas. Wales has its own healthcare system – NHS Wales – comprising Local Health Boards, NHS Trusts and Public Health Wales ('PHW'). Relevant offices and agencies such as the Office of the Chief Medical Officer ('CMO') and Care Inspectorate are specific to Wales.

11. The Welsh Government confirmed in its evidence that the Minister for Health and Social Services has responsibility for the NHS in Wales and all aspects of public health and health protection. Further, it has been confirmed that the health minister is responsible for preparedness for the NHS and healthcare sector, NHS initial capacity, and capacity and resilience.[7] Its evidence also confirms that the Health and Social Care department led on planning for the identified risk in the national risk register of pandemic influenza.[8]

12. Cabinet Office Guidance made clear that "*devolved administrations are responsible for the major areas of pandemic influenza planning and response in their respective countries*"[9] and that the Wales Resilience Forum chaired by the First Minister "*provides the mechanism for a national multi-agency overview of pandemic preparedness in Wales.*"[10] In terms of response, Wales had in place its own Pan Wales Response Plan approved in 2005 setting out its command control and co-ordination urgent response structure.[11] In terms of preparedness and response, the Wales Framework for Managing Major Infectious Disease Emergencies was originally produced in 2005.[12] It was in its 2014 iteration on going into the pandemic. The framework "*reflects the role of the Welsh Government's Department of Health and*

[7] Dr Andrew Goodall No. 2 para 62 (INQ000184901)
[8] Sir Frank Atherton Transcript 6 July 2023 pp 126-127
[9] Guidance on Pandemic flu planning information for England and the Devolved Administrations, including guidance for organisations and businesses, 24 November 2017 (INQ000022847)
[10] Guidance from Cabinet Office, Department of Health and Social Care, Ministry of Housing, Communities & Local Government, Home Office, and Ministry of Justice, regarding Pandemic Flu at p 21 (INQ000022847)
[11] Mr Reg Kilpatrick para 61 (INQ000190662)
[12] Dr Andrew Goodall No. 1 para 168 (INQ000130469)

Social services in managing major infectious disease outbreaks in Wales" and "*provides a framework for operational planning*"[13]. Alongside it the Welsh Government produced the 2014 guidance "Wales Health and Social Care Influenza Pandemic Preparedness & Response Guidance".[14]

13. The Civil Contingencies Act 2004 (CCA 2004) Part 1 provides for a generic civil contingencies structure imposing duties on a list of first responders. However, as has been noted in the evidence before the Inquiry,[15] local government and the NHS who are key category 1 responders under CCA 2004, fall under the remit and control of the Welsh Government by virtue of the devolution settlement. Whilst the Welsh Ministers (Transfer of Functions) Order 2018/644 from May 2018 transferred to Welsh Ministers specific powers under CCA 2004 to issue guidance, exercise monitoring functions and specific enforcement power, make regulations, and amend the list of devolved Welsh responders,[16] this relates to the specific structure provided for by the CCA 2004 Part 1. Pandemic preparedness was in any event at all times a devolved matter, the Welsh Government having statutory powers and responsibility in this area throughout regardless of how responsibilities were allocated under the generic CCA 2004 structure.

Planning assumptions in Wales were fundamentally flawed

14. Pandemic planning and preparedness for Wales was flawed in the same fundamental way as planning in the rest of the UK, in that the focus was solely on planning for an influenza pandemic. The consequences of this failure were stark. The focus was not on halting community transmission as it should have been or thinking about non pharmaceutical interventions. This had devastating consequences when Covid-19 arrived in Wales and the UK. PPE was not available for healthcare professionals, there was a failure to understand the importance of mask-wearing and need for large scale contact tracing and testing. Mass gatherings were not cancelled and there was no awareness of the need for quarantining and social distancing.

[13] Wales Framework for Managing Major Infectious Disease Emergencies, October 2014 (INQ000184289)
[14] February 2014 Guidance (INQ000116503); Dr Andrew Goodall No. 1 para 168 (INQ000130469)
[15] Mr Chris Llewelyn (on behalf of the Welsh Local Government Association) para 87 (INQ000177802)
[16] Dr Andrew Goodall No. 1 para 153 (INQ000130469)

15. The Inquiry has heard much evidence on this subject: the focus on an influenza pandemic which characterised the key UK planning guidance, the UK Influenza Pandemic Preparedness Strategy 2011. Key guidance in Wales, in the Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance 2014 (which remained the relevant guidance on going into the pandemic), as is obvious from the name, had the same focus on an influenza pandemic. Whilst a second key planning document in Wales, the Wales Framework for Managing Major Infectious Disease Emergencies, October 2014, is not specific to influenza, the evidence was that the UK strategy was the framework that all worked within and set out the strategy that translated through.[17]

16. In October 2015, Public Health Wales (PHW) led exercise Dromedary/2nd bite,[18] which was to be the only exercise undertaken in Wales in relation to a coronavirus outbreak. This exercise was intended to test the response to a single case of MERS in a Welsh hospital.[19] As such, this exercise could not be said to have been an exercise designed to test the Welsh healthcare system's resilience and/or preparedness for a coronavirus pandemic. Following this exercise, PHW updated its Emergency Response Plan ('ERP'), which was approved on 27 September 2018.[20] The key change in the plan was from a five-tier response structure to a three-tier response structure.[21] The ERP does nothing to address the specific risk of a SARS/MERS pandemic[22] and the updated ERP features only general guidance on incident levels and activation and command and control with no reference to either pharmaceutical or non-pharmaceutical measures.[23] Therefore, despite the threat of a coronavirus with widespread impact being a known risk,[24] the only coronavirus exercise carried out in Wales tested the response to a single case of MERS rather than a coronavirus having reached pandemic level. The exercise did not lead to the development of any planning documents specific to a SARS

[17] Dr Andrew Goodall Transcript 4 July 2023 p23; Letter from Welsh Government regarding ATISN 15194 – Pandemic Planning, dated July 2021 (INQ000148446)
[18] Report from Public Health Wales titled Exercise Dromedary (INQ000089608); Report from Public Health Wales, titled Emergency Response Plan (INQ000089562)
[19] Dr Quentin Sandifer para 242 (INQ000192266)
[20] Public Health Wales Emergency Response Plan Version 2.0, September 2018 (INQ000089558)
[21] Dr Quentin Sandifer para 88 (INQ000192266)
[22] INQ000089558
[23] Dr Quentin Sandifer para 87 (INQ000192266)
[24] Dr Quentin Sandifer para 143 (INQ000192266), Public Health Wales report by Gwen Lowe, titled Airborne Isolation Rooms Review Working Group- on behalf of Welsh Government (INQ000089594)

pandemic. At the time of Covid-19 all of the Welsh Health Boards and NHS Trusts only had pandemic influenza plans in place and the Welsh Government based its response to the Covid-19 pandemic on the 2011 influenza strategy. The four Welsh LRFs each had multi-agency arrangements for pandemic influenza setting out procedures for co-ordination in their LRF area, but none had SARS plans in place.[25]

17. The consequences of such limited scope to pandemic preparedness have been spelt out in the evidence the Inquiry has heard. Dr Quentin Sandifer in his witness statement said that PHW "*was not able to fully envisage the pace of spread, scale, impact and duration of Covid-19 at the outset of the pandemic.*"[26] Further, in his oral evidence, he said that he had not envisaged circumstances where whole society would be locked down or, indeed, a whole country.[27] He said, in fact, that "*lockdowns took us into completely unchartered territory*".[28]

18. These failures in planning assumptions were unjustifiable. The world had already experienced 2 coronavirus pandemics or major epidemics in the 21st century: SARS and MERS. Both had a profound effect in East Asian countries[29] and as a result those countries had learnt lessons about pandemic planning and preparedness.[30] The lessons learnt by the East Asian countries were readily available in the WHO literature[31] and could and should have been used in the UK including in Wales's pandemic planning. The Inquiry heard evidence from Professor Heymann and Dr Richard Horton who gave poignant evidence of how since 2004 the global community knew that coronaviruses were a major threat, yet that there was a general group think in the UK to only focus on the threat of influenza. In his evidence, Mr Jeremy Hunt's description of attitudes pointed towards a group think that nothing could be learned from other countries.[32] As a consequence, those who were compiling the key policy documents were prisoners of their own ill-informed assumptions.

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[25] Letter from Welsh Government regarding ATISN 15194 – Pandemic Planning, dated July 2021 (INQ000148446)
[26] Dr Quentin Sandifer para 201 (INQ000192266)
[27] Dr Quentin Sandifer Transcript 4 July 2023 pp 90-91
[28] Ibid.
[29] Professor David Heymann Transcript 15 June 2023 p 53
[30] Ibid. p 54
[31] Ibid. p 59
[32] Mr Jeremy Hunt MP Transcript 21 June 2023 p 169

19. When giving evidence, Mr Mark Drakeford, First Minister for Wales, was asked whether in his former role as Health Minister or current role as First Minister he had asked about the risk of a novel virus or a Disease X breaking out and whether Wales was prepared, to which he responded he did not. Mr Drakeford had first-hand experience of responding to threats such as SARS, MERS, and Ebola during his political career in Wales. CBFJ Cymru considers that the threat of pandemic requires a much more robust spirit of political enquiry. Mr Drakeford was not the only minister who did not ask the questions that needed to be asked. There needs to be an across-the-board change in mindset as regards thinking about and discussing scientific opinion on pandemic risk.

20. As stated, there had been warnings of a non-influenza pandemic but these warnings were not heeded. As far back as 2013, at Wales's own Health Emergency Preparedness Unit (HEPU)'s annual pandemic planning conference, Dr John Watkins (now Professor Watkins, who has provided a witness statement to the Inquiry[33]), could be heard talking about current threats which included a novel virus with little background immunity, no available vaccine, and raised the question of possible transmissibility akin to the Spanish Influenza pandemic.[34] In 2013, Professor Watkins was a consultant epidemiologist at PHW. CBFJ Cymru ask the Inquiry to get to the bottom of whether the Welsh Government was in fact warned about the risks of a novel virus and if so, why such warnings were not heeded.

21. It is clear that in Wales as in the UK there was a woeful failure to ensure that pandemic planning was underpinned by adequate scientific enquiry and understanding of what the risks were and what needed to be planned for. At core there was a lack of adequate engagement and leadership by governments (UK and Welsh Government) on the subject of pandemic threat.

22. To ensure that such flawed planning assumptions do not continue, the right structures must be put place to ensure not only that risk assessments that underlie risk registers and plans are properly and fully informed by scientific opinion but also that there is

33 INQ000217260
[34] Report from Welsh Government, titled Health Prepared Wales 2013 Pandemic Influenza p 4-5 (INQ000144624)

robust scrutiny and transparency in relation to the scientific thinking that informs them. How risks are planned for requires serious review so that planning is appropriately wide, and this requires consideration of switching focus to scenarios and capabilities.[35]

Risk registers – insufficient attention paid to pandemic risk

23. The failure by the Welsh Government to accord the high priority that should have been accorded to the issue of pandemic preparedness is evident from the way pandemic risk was dealt with on Welsh Government risk registers.

24. Whilst there is a health and social care departmental risk register (referred to further below),[36] there has been no central Welsh Government risk assessment process and register other than its corporate risk register and this, from 2016, ceased making explicit reference to the specific risk of a pandemic.[37] The Inquiry heard the evidence of Dr Andrew Goodall that from 2016 the way the risk was included on the corporate risk register was reviewed.[38] The risk of a pandemic ceased to be expressly identified as a specific risk. The Inquiry heard that pandemic risk was included only by means of a general heading for a group of risks. For example, on the 2019/20 register, the heading is "Disruption Events, Affecting People, Places, Finances, Communications and IT".[39] Therefore there was no express recognition apparent on the face of the corporate risk register from 2016 of a pandemic as a specific risk, let alone recognition that this was the Tier 1 national risk and there was no statement on that register of specific mitigation measures for a pandemic, but rather general mitigation measures directed to a group of risks. When examined in oral evidence about the 2019/2020 corporate risk register Dr Goodall conceded that the stated mitigation measures were "*too generalised, and that*

[35] The approach referred to in the submission on behalf of the Government Office of Science, Transcript 19 July 2023 p 49

[36] HHSSG Registers: INQ000216936 (2017); INQ000216952 (May 2019); INQ000216953 (May 2019); INQ000216956 (February 2019); INQ000216957 (February 2019); INQ000216958 (February 2019); INQ000216961 (August 2018); INQ000216962 (August 2018); INQ000216965 (August 2019); INQ000216966 (August 2019); INQ000216969 (January 2020); INQ000216970 (January 2020); INQ000216972 (April 2016); INQ000216973 (May 2016)

[37] Corporate Risk Registers: INQ000216623, INQ000215556 (2016), INQ000215551, INQ000216622 (2017), INQ000215557, INQ000216621 (2018), INQ000215558 (2019)

[38] Dr Andrew Goodall Transcript 4 July 2023, pp 11-12. See also Dr Andrew Goodall No. 1, paras 161-163 (INQ000130469)

[39] Welsh Government Corporate Risk Register for Q1 2019/20 (INQ000215558)

probably gave some inappropriate assurance on arrangements in there" and as regards the risk score, "*the residual score in hindsight should have been higher at that time*".[40]

25. The significance in practical terms of the absence of specific express reference to the Tier 1 risk of a pandemic on the corporate risk register is underlined by the evidence of Mr Mark Drakeford; that he would expect the corporate risk register to be used by senior officials to draw the attention of ministers to areas where senior officials believe ministerial intervention would be necessary.[41] The Inquiry also heard from Mr Drakeford that the Welsh Government, since Covid-19, now recognises that Wales should have its own national risk assessment process of interpreting and adapting UK level risks to Wales.[42]

26. Pandemic flu and other health emergencies preparedness were dealt with on the relevant departmental risk register – the Health and Social Services Group (HSSG) risk register.[43] However, some of the criticisms in relation to the corporate risk register also apply to the HSSG risk register:

    a. The specific risk of a pandemic is not given its own rating on the register but instead it refers to "resilience", which addresses chemical, radiological, nuclear and biological risks and "mass casualty" events;
    b. As a result of the generic nature of the risk identified, the mitigating measures to combat the risks are equally generic;
    c. The changes to the residual risk (namely that the risk is shown as reduced in some years) do not appear to reflect the findings following the Cygnus Exercise 2016;
    d. A no-deal Brexit was considered a greater residual risk than resilience. Given the findings of the Cygnus Report, which was published in 2017, it is submitted that the risk of a pandemic should have been considered at least as great a residual risk as a no-deal Brexit because Cygnus revealed that the mitigating measures currently in place were not sufficient to meet the challenge of a pandemic. Alternatively, it could be said that a pandemic is always going to

[40] Dr Andrew Goodall Transcript 4 July 2023, pp. 21-22
[41] Mr Mark Drakeford MS Transcript 4 July 2023, p 184
[42] Ibid. p 178
[43] Dr Andrew Goodall Transcript 4 July 2023, p 12

have a greater residual risk than a no-deal Brexit due to the number of excess deaths likely to result from either scenario; and

e. The mitigating measures do not change year on year, nor do the descriptions of the risk, yet the residual risk decreases. It is difficult to understand how the mitigating measures identified can be said to reduce the residual risk.

27. In May 2016, under the heading of "Resilience" it is said that "*Pandemic flu is the top national risk [...] high probability of another influenza pandemic where half the population could experience symptoms [...] The recent spread of diseases such as Ebola and MERS CoV are also a cause for concern.*"[44] The residual risk in this register is amber. The position is identical in 2017. However, the "resilience" risk (i.e. the one which addresses the risk of a pandemic) is reduced to a yellow residual risk in February 2019.[45] It is difficult to see how the mitigating measures identified within this document have resulted in the residual risk being reduced when so many workstreams had been halted or interrupted due to Operation Yellowhammer (see the references to the evidence below on this). By contrast, in February 2019, the residual risk of a no-deal Brexit is given a red residual risk rating.

28. Further, there are other aspects of general healthcare system resilience identified within these HSSG risk registers which should represent a cause for concern in relation to pandemic response. In particular, in the February 2019 HSSG Risk Register it is said that "*Current microbiology/infection services in Wales are fragile and are struggling to deliver on a day to day basis the prevention, early diagnosis and frontline support*". The mitigation includes an additional £1 million funding (the state of affairs regarding microbiology/infection services in Wales at this time is further referred to below). In the May 2019 register it is stated: "*HEPU carrying multiple vacancies for a prolonged period of time. Lack of staff due to Brexit. Should an incident occur, insufficient staff in the team.*" Still, a no-deal Brexit has a red residual risk in comparison to the yellow/amber residual risks for pandemic preparedness or generic resilience in the healthcare system. There is reference to "*residual fragility*" in the healthcare system which is not reflected in the residual risk calculated within the register itself.

[44] HSSG Risk Register dated May 2016 (INQ000216973)
[45] HSSG Risk Register dated February 2019 (and annexes) (INQ000216956; INQ000216957; INQ000216958)

29. It is because the HSSG risk assessments were disclosed so late by the Welsh Government that these criticisms could not be raised with the Welsh Government witnesses for their response. These documents were not provided to the Inquiry until a very short time before the first of the witnesses gave evidence,[46] and consequently disclosure to CPs was also late and not until after Welsh Government witnesses had given their evidence. It is regrettable that the Welsh Government disclosed the risk registers so late on in the process of the Inquiry.

Inadequate formal planning and testing, and failure to implement learning from pandemic planning exercises

30. As the Inquiry has heard, formal pandemic planning was woefully inadequate, even when judged on the basis of its own planning assumptions. There was no finished plan or testing for surge capacity following Exercise Cygnus (see further below). Despite guidance in place since 2014 stipulating planning should be carried out for 12-15,000 excess deaths in Wales possibly over as little as 15 weeks, this work was not completed.[47] The witnesses to the Inquiry have not given a satisfactory explanation for these failures.

31. The learning and actions indicated from formal planning were not actioned at all or adequately. For example, the Welsh Government knew that there would be a burden on care homes and the care sector in the event of a pandemic but the work was not completed to deal with this.[48] There was a systemic failure to deal with infection control which is addressed at paras 40-47 of these submissions.

32. Wales participated in the national Exercise Cygnus 2016 which gave rise to a finding that UK's preparedness and response "*in terms of its plans, policies and capabilities*" was "*not sufficient to cope with the extreme demands of a severe pandemic that would*

[46] See Transcript 3 July 2023 p 77
[47] Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance, February 2014 (INQ000089573); Mr Vaughan Gething MS Transcript 4 July 2023 p 150-151
[48] Draft Report from Wales Resilience, titled Response to Swine Flu in Wales 2009/2010: Lessons Identified Report, 1/8/2010 (INQ000107131); WRF(10)4 – Response to Swine Flu – Lessons Learnt, regarding conclusions and recommendations on lessons in the response to Swine Flu (INQ000107129); Project Initiation Document, Social care surge in Wales during a flu pandemic, 2/7/2018 (INQ000187173)

have a nationwide impact across all sectors".[49] There were 4 key learning outcomes and 22 detailed lessons with 12 recommendations that had been identified in an earlier document specifically with reference to Wales.[50] The report also stated that consideration should be given to reviewing the UK's Influenza Preparedness Strategy 2011 and individual government department pandemic influenza plans in the light of the key findings.[51]

33. It might have been expected that the Welsh Government would take swift action but that was not the case. The Inquiry has heard from Sir Frank Atherton that he was aware of HEPU maintaining a log of progress on the outcomes, but has also heard that workstreams were not completed and whilst it was recognised that the Welsh strategic documents required to be updated, this did not happen.[52] Going into the pandemic, key guidance documents on pandemic preparedness and response: the Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance; the Wales Framework for Managing Infectious Disease Emergencies remained in their 2014 versions, and had not been updated in light of the Cygnus Exercise report. The Local Resilience Forum Pandemic Flu 2013 guidance was also not updated.[53] The Inquiry heard evidence that concern was raised by Mr Reg Kilpatrick in July 2018 regarding the Welsh Government's levels of engagement and provision of resource to the progress of pandemic influenza preparedness.[54] This work mattered, as was acknowledged by Mr Reg Kilpatrick in his evidence that "*we would have been in a better position had the plans been updated*".[55] Notwithstanding the concerns raised, no further resource was committed to pandemic planning and no further work was completed in respect of the guidance[56].

34. As regards the workstreams after Exercise Cygnus 2016, the Welsh Government set up the Wales Pandemic Flu Preparedness Group in order to progress them, but this group

[49] Report by Public Health England, titled 'Exercise Cygnus Report - Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016' (INQ000056232)
[50] Exercise Cygnus Wales De-Brief Report October 2016 (INQ000128979); Dr Andrew Goodall Transcript 4 July 2023 ps 37-38
[51] Exercise Cygnus Report p 6
[52] Sir Frank Atherton Transcript 3 July 2023 p 37; Dr Andrew Goodall Transcript 3 July 2023 p 94-95
[53] Mr Reg Kilpatrick Transcript 6 July 2023 p 149; Sir Fank Atherton Transcript 3 July 2023 p 28
[54] Mr Reg Kilpatrick Transcript 6 July 20 pp 145-148 ; email correspondence July 2018 (INQ000180484)
[55] Mr Reg Kilpatrick Transcript 6 July 2023 p 150
[56] Sir Fank Atherton Transcript 3 July 2023 p 52-53

met for the last time in October 2018.[57] As the Inquiry has revealed, there were many tasks, but they were not finished.[58] The Inquiry heard evidence that the work in Wales was in effect shadowing that of the UK-wide group and that actions in Wales were predicated on the revision of the 2011 plan.[59] However, it is clear there was no impediment to the Welsh Government getting on with drawing up plans and guidance: Dr Andrew Goodall informed the Inquiry that some plans were updated[60] and *draft* plans were drawn in some areas[61]. These things could and should have been progressed to fruition with greater urgency.

35. Wales's health and social care systems needed to be able to meet the needs of people in Wales which includes in the face of the known risk of a pandemic. Putting in place what was needed should not have taken years to accomplish. The failure to do this meant that, when Covid-19 hit, Wales's health and social care infrastructure was simply not able to cope. This was an unforgivable failure not least because the November 2009 report following Exercise Taliesin and Swine Flu had contained a specific recommendation about the need to develop capacity in the adult social care sector in order to cope with the demands of pandemic.[62] This had not been resolved by the time of the 2016 Cygnus Exercise and it was still not resolved when Covid-19 hit despite the Cygnus Report highlighting the prospect of demand outstripping capacity in this area requiring consideration of arrangements for "scaling up",[63] Those whom CBFJ Cymru represents experienced the consequences of these shocking failures in preparation and planning. Many loved ones lost their lives in hospitals and care homes in traumatic circumstances with inadequate means of protection.

36. Nor should it have been necessary or thought appropriate to stall work on preparations for the Tier 1 risk of a pandemic as soon as second potential emergency, also requiring preparedness steps to be taken, came along – namely a potential no-deal EU exit. The

[57] Mr Mark Drakeford Transcript 4 July 2023 p 190
[58] Dr Andrew Goodall Transcript 3 July 2023 pp 94-5
[59] Sir Frank Atherton 3 July 2023 Transcript p 43
[60] Dr Andrew Goodall 4 July 2023 Transcript p 24
[61] Ibid. p 40
[62] Exercise Taliesin/Swine Flu Structured Debriefing Report (INQ000128976)
[63] Exercise Cygnus - Recommendations, regarding recommendations following exercises assessing preparedness p 8 (INQ000107136)

appropriate degree of priority was simply not being accorded to a Tier 1 risk of a pandemic.

Insufficient engagement by ministers in pandemic planning issues

37. A clear picture emerges from the evidence of a lack of adequate attention paid to pandemic preparedness at all levels of government over a long period. The Inquiry heard from Mr Vaughan Gething MS, Minister for the Economy, who served from September 2014 as Deputy Minister for Health, from May 2016 as Cabinet Secretary for Health, Well-being and Sport and latterly Minister for Health and Social Services until May 2021. Mr Gething told the Inquiry that before October 2016 pandemic risk for Wales "*wasn't, as it were, brought to my direct attention that it was something that I needed to be particularly prepared for. I had other priorities, not this*".[64] He said that whilst he became aware that pandemic was a priority in Wales in the run up to Exercise Cygnus, before then, he had not understood that pandemic risk was in the Tier one risk register.[65] He did not read the National Risk Register.[66] He acknowledged that he did not read the plans that the witnesses had been referred to on taking up the post – stating that for a minister it is about how the overall system is prepared – and that he first read the 2011 Influenza Strategy when preparing for the Inquiry.[67] He candidly admitted that pandemic preparedness did not have the same priority as "*those headline issues*" that did take up lots of the life and energy of the government and that there is "*a lesson learning point*" arising from the challenge of dealing with what comes up and longer term priorities.[68] We heard from Mr Gething that he was advised that Cygnus learning points had been identified and would be implemented and that he assumed absent any advice to the contrary or questions in the Senedd that the lessons of Exercise Cygnus had been applied.[69] Nor did Mr Gething read the report of the outcome of Cygnus Exercise and admits that had he read the conclusion about lack of preparedness on page 6 of the report already referred to (namely that which states the UK was not capable of coping with extreme demands of a severe pandemic) he would almost certainly have

[64] Mr Vaughan Gething MS Transcript 4 July 2023 t 2023 p 108
[65] Ibid. p 110
[66] Ibid. p 111
[67] Ibid. pp 113-115
[68] Ibid. 2023 pp 125-126
[69] Ibid. pp 130-132; Mr Vaughan Gething, para 68 (INQ000187304)

asked extra questions and asked for more assurances about what was happening.[70] He accepted that it was fair to say that if he had put more time into this then he may well have "*sped up preparedness*".[71] It is indefensible that the high level ministerial oversight needed for such an important issue was simply absent.

System at risk of fragmentation and gaps

38. The Welsh Government was warned 8 years before Covid-19 hit that there was a risk of a fragmented system and of gaps in dealing with pandemic resilience in Wales in which accountabilities were unclear. No action was taken.

39. A Wales audit report of December 2012 on Civil Emergencies in Wales[72] reported that "*too many emergency planning groups and unclear accountabilities add inefficiency to the already complex resilience framework*" and that "*the complexity risks fragmentation of resilience activity with potential overlaps or gaps in the arrangements for resilience*". This structure did not significantly change prior to the Transfer of Functions Order under the Civil Contingencies Act 2004 in 2018 and Mr Mark Drakeford, First Minister for Wales, accepted in oral evidence that a review of civil contingencies arrangements remained outstanding on going into the pandemic.[73] The failure to act with any sense of urgency over such a long period in the face of the warnings in the audit report is yet another failure by the Welsh Government to accord the priority to pandemic preparedness that should have been accorded to a Tier 1 risk.

Lack of implementation and follow up on existing preparedness guidance – infection prevention and control infrastructures

40. A matter of real significance to CBFJ Cymru is hospital acquired Covid-19. Many people in Wales died because they caught Covid-19 in Welsh hospitals. The subject of what was done to counter inadequate ventilation and poor infection control is therefore a very pressing one.

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[70] Mr Vaughan Gething MS Transcript 4 July 2023 p 132
[71] Mr Vaughan Gething MS Transcript 4 July 2023 p 133
[72] INQ000107113
[73] Mr Mark Drakeford MS Transcript 4 July 2023, pp 167, 170, 174-6.

41. The Inquiry has heard evidence (in particular from Professor David Alexander and Bruce Mann) about the need for frameworks to quality assure steps set out in strategies and guidance.[74]

42. It is clear from the evidence there has been a lack of a robust and systematic follow up to ensure that what the Welsh Government's *own* guidance said needed to be in place in order to be prepared for a pandemic was actually put in place. This is particularly borne out in the case of infection control infrastructure. There is clear evidence that in the area of infection prevention and control there was a significant gap between what was stated in the key pandemic preparedness guidance documents and the reality on the ground before the pandemic hit. The Welsh Government's key pandemic preparedness guidance documents of 2014 (which remained in force up to the pandemic) identified the need to be prepared in infection prevention and control arrangements: the need for "*meticulous use of infection control, isolation and cohort nursing*"; and "*all hospitals need to establish ways of caring for large number of infectious patients on a scale outside their normal experience.*"[75]

43. Yet the evidence before the Inquiry is that before the pandemic struck, far from having the infrastructure for infection prevention and control services in place with resilience and capacity to scale up and be able to provide what would be needed in the event of a pandemic, arrangements in this area were fragile even on a day-to-day level. This is seen from a paper prepared for the Health Protection Advisory Group in July 2019 (six months before the pandemic struck); exhibited to the witness statement of Sir Frank Atherton stating:

"*the current microbiology/infection services in Wales are fragile and are struggling to deliver on a day to day basis the prevention, early diagnosis and frontline support that professional and the public require*".[76]

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[74] Expert Report on Resilience and Preparedness by Professor David Alexander and Mr Bruce Mann para 242 (INQ000203349)
[75] Wales Health and Social Care Influenza Pandemic Preparedness & Response Guidance, February 2014 p 15 (INQ000089573); Wales Framework for Managing Infectious Disease Emergencies October 2014 (INQ000184289)
[76] INQ000177362

44. Sir Fank Atherton agreed, in oral evidence, that this area was a major concern.[77] The issue is also evident from the reasons given for a request for funding made by the Health Protection Group in September 2019 (exhibited to Dr Goodall's third witness statement): that laboratory estates on many sites were "*no longer fit for purpose*" and that there was a "*need for increased ward-based clinical services to support infection prevention*".[78] Whilst the money requested was provided, it is significant that this was on the eve of the pandemic. While Dr Goodall gave evidence that things were being done prior to 2019 to seek to improve infection prevention and control[79], the inescapable conclusion is that the 2014 pandemic preparedness guidance had not been translated into action to ensure a resilient system ready for the much greater demands in the event of a pandemic.

45. There is also the matter of hospital facilities for isolation and high consequence infectious disease (HCID). Since 2004, the Welsh Government and those responsible for pandemic planning and preparedness in Wales have known about a particular vulnerability in the Welsh healthcare system, namely the lack of facilities to deal with HCIDs. A publication by the Welsh Assembly Government (as it then was) in 2004, "Healthcare Associated Infections – A Strategy for Hospitals in Wales"[80] compiled in the wake of the 2002-2004 SARS outbreak provided a "*timely reminder that not only should sound and evidence-based infection control policies be in place but considerable attention must be paid to ensuring that they are rigorously and consistently applied.*"[81] Among the infection prevention and control measures in the strategy were isolation facilities with effective negative pressure ventilation.[82] Since 2006, NHS Wales has surveyed and produced an annual report on all airborne isolation rooms in major hospitals across Wales. Every year the reports have concluded that many of these airborne isolation rooms are inadequate.[83] In 2017, the Airborne Isolation Rooms Review Working Group produced a report to inform policy on airborne isolation rooms in major acute hospitals, concluding that building structures did not support safe

[77] Sir Frank Atherton 3 July 2023 Transcript p 66
[78] INQ000177552
[79] Dr Andrew Goodall Transcript 4 July 2023, pp 54-5
[80] INQ000145726
[81] INQ000145726, p 25
[82] INQ000145726, p 29
[83] Report from Gwen Lowe (Public Health Wales), titled Airborne Isolation Rooms Review Working Group- on behalf of Welsh Government, dated 18/10/2017 p 2 (INQ000089594)

management of patients with infectious disease.[84] Further, there was not one single health board in Wales capable of dealing with one HCID.[85] Dr Quentin Sandifer raised this with the CMO Sir Frank Atherton in July 2019.[86] In December 2019, Sir Frank Atherton raised the issue in a meeting of the Health Protection Advisory Group.[87] The situation as of January 2020 was that there was not one single hospital in Wales capable of dealing with a person presenting with a HCID.[88] This meant the first patients in Wales with Covid-19 (considered a HCID until March 2020) were transferred to hospitals in London or Newcastle,[89] despite the working group's recommendation in 2017 that there should be one unit in every health board in Wales.[90]

46. When asked about this, Dr Quentin Sandifer said it was an issue which had not been adequately dealt with over a very long period of time, and that the health boards in Wales were still "*on a journey*",[91] but that Wales was not in the position he would have liked as of 2019.[92]

47. The fact remains that, as of January 2020, there remained a lack of facilities to deal with HCIDs, despite this having been an issue raised by numerous bodies and in numerous reports over 16 years. CBFJ Cymru submits that this demonstrates a lack of urgency in Wales to deal with the threat new and emerging diseases and a false belief that "it won't happen here". CBFJ Cymru urge the Inquiry to robustly examine issues relating to infection control in hospitals in Wales in Module 2b.

PPE

48. The Audit Wales's report, "Procuring and supplying PPE for the Covid-19 Pandemic"[93] of April 2021 demonstrates that PPE stockpile for Wales was inadequate, not just for a coronavirus pandemic, but for the pandemic planned for, namely influenza with waves

[84] INQ000089594, page 13
[85] INQ000089594, page 14
[86] Dr Quentin Sandifer Transcript 4 July 2023, p 104
[87] INQ000177380, page 4
[88] Dr Quentin Sandifer Transcript 4 July 2023, p 104
[89] Sir Frank Atherton Transcript 3 July 2023, p 64
[90] INQ000089594, p 3
[91] Dr Quentin Sandifer Transcript 4 July 2023, p 105
[92] Ibid. p 106
[93] INQ000066526

lasting 15 weeks.[94] Mr Vaughan Gething in his evidence conceded the plan for an influenza pandemic would have still presented challenges even if there had been an influenza pandemic rather than a coronavirus pandemic. As for the distribution arrangements, Mr Gething MS in oral evidence explained that the Welsh Government operated a just-in-time system. He conceded that supply chains in place in 2020 were long and fragile and collapsed in the face of the Covid-19 pandemic.[95] Therefore, we glean from all of this that there were built-in weaknesses which would apply to an influenza pandemic as they did to Covid-19. As regards distribution, Dr Andrew Goodall gave evidence that a change to the distribution model was required and that the scale, severity, and duration of the arrangements required more work.[96]

49. More work could and should have been done in preparation for a pandemic to ensure both a sufficient stockpile of PPE (by sufficient, CBFJ Cymru would expect there to be a sufficient quantity of in-date PPE of the correct type) and a robust distribution system. These issues are symptoms of thematic failures in preparedness: flawed planning assumptions, insufficiency of live or semi-live exercises, and of follow-up on recommendations when given.

Pre-existing inequalities considered in only a minimal way

50. Public bodies are under a duty to specifically consider equality issues in their policies and guidance by virtue of Equality Act 2010.

51. Compelling evidence was given by Professors Bambra and Sir Michael Marmot of how whole system catastrophic shocks expose and amplify pre-existing health inequalities. Indeed, Welsh Government accept in the context of COVID-19 *that the pandemic has exacerbated the situation for many people who are already the most disadvantaged or potentially neglected in our society, worsening pre-existing inequities*.[97] The findings of Professors Bambra and Sir Michael Marmot were that "*pre-existing health inequalities were only considered in a minimal way in the UK's and devolved*

[94] INQ000066526, p 21
[95] Mr Vaughan Gething MS 4 July 2023 Transcript p 141
[96] Dr Andrew Goodall 4 July 2023 Transcript p 56
[97] Sir Frank Atherton (INQ000184902) para 50

administrations' pandemic planning and then largely in relation only to age and clinical risk factors. Wider issues of vulnerability (such as socio-economic status or ethnicity) were seldom considered in the UK devolve administrations planning documents". [98]

52. The evidence before the Inquiry of pandemic planning in Wales is consistent with that finding. While the Inquiry heard that PHW's ERP made references to vulnerabilities, it made no explicit references to those with comorbidities, older people or health inequalities.[99] There is also evidence of insufficient consideration of risk factors and potential impacts on those with protected characteristics and other markers of vulnerability within emergency planning and risk assessment at local authority level as at January 2020, as demonstrated by the data captured within Table 16 of the LGA Covid-19 Inquiry Survey for Module 1 dated November 2022.[100]This Table demonstrates that the characteristics most commonly considered within Welsh local authority emergency plans were people in care homes (68% of plans), clinically vulnerable people (68% of plans) and age (64% of plans) and the least likely to be considered were gender reassignment (5% of plans), sexual orientation (5% of plans), victims of domestic violence (14% of plans), sex (23% of plans), race (23% of plans) and religion (36% of plans). It is notable that in respect of every characteristic assessed, the percentage of plans and risk assessments considering the risk factors and potential impacts in respect of that characteristic was lower in Welsh local authorities than their English counterparts.

53. Within the Wales debrief report on Exercise Cygnus dated October 2016,[101] the final recommendation was for the Welsh Government and local resilience "*to consider options for identifying people at risk during a flu pandemic and how resources from public services, voluntary sector, communities and individuals can be best used to provide targeted support*". Mr Reg Kilpatrick acknowledged in his evidence that "*there is a good deal more to do*"[102] in respect of this recommendation. When asked to confirm whether, going forward, it would be a priority for the Welsh Government that those

[98] INQ000195843, para 146
[99] Dr Quentin Sandifer 4 July 2023 Transcript pp 98-99
[100] Draft Report from Local Government Association, titled COVID-19 Inquiry Survey for Module 1, Research Report, dated November 2022 (INQ000082855) p 35
[101] De-Brief Report, titled Exercise Cygnus, dated October 2016 (INQ000128979)
[102] Mr Reg Kilpatrick 6 July 2023 Transcript p 139

who are likely to be the heaviest affected by any sort of civil contingency emergency are considered, Mr Kilpatrick agreed that "*to the extent that we can include, identify and work with vulnerable people, we most certainly will*".[103]

54. As to the extent to which pandemic planning can and should consider inequalities, Mr Mark Drakeford, First Minister for Wales, boldly suggested that "*the advice from Public Health Wales to us was, that while you had to be aware of the unequal impact of a pandemic on the population, it was very difficult to anticipate in advance of the particular nature of that pandemic where those inequalities would most fall. So while there is evidence in the documentation of awareness of inequality and the way in which a pandemic would exaggerate existing inequalities and therefore had to be planned for from the outset, the more granular planning, which groups would be affected, how would you respond to them, you'd have to do that when the nature of the pandemic you were dealing with became more apparent. You -- it just wouldn't be possible to plan without that greater knowledge*".[104]

55. This proposition was put to Professor Kevin Fenton who essentially disagreed, stating "*You won't be able to do everything in planning to mitigate the impact of inequalities, but there is still a lot that can be done*".[105] He went on to explain what these measures might "*include co-production with -- in the plans, and ensuring that in the development of the plans you have due regard to tackling inequalities, which go beyond the equality impact assessment, but co-producing, for example, with local partners who are in contact with local communities or vulnerable communities to ensure those perspectives are included in your plans and your plans are tested against those perspectives. Second, you can ensure that you have the mechanisms in place to engage with and to access those communities which are at greatest risk, either through -- understanding your communication channels, for example. How do you reach out to and engage with vulnerable communities? How are you working with the voluntary and community sector, and what mechanisms are in place either in local government to assure ourselves that we have the routes of communication and outreach to engage with vulnerable communities? Then, finally, ensuring that data and the infrastructure for data and data*

[103] Mr Reg Kilpatrick 6 July 2023 Transcript p 139
[104] Mr Mark Drakeford MS Transcript 4 July 2023 p 206
[105] Professor Kevin Fenton Transcript 5 July 2023 p 89

sharing are available and are designed before the pandemic or before the shock, so that you're able to capture the information that you need to characterise and to understand the impact on vulnerable populations. So those are things that can be done prior to an event which then set a stronger foundation for your response for equity in the event".[106]

56. Further, evidence was given by Mr Marcus Bell of the Equality Hub and Ms Melanie Field of the Equality and Human Rights Commission on how public bodies should approach pandemic planning with sufficient regard to inequalities. Their evidence was that pandemic plans across the board should be formulated to take account of a process of meaningful engagement with relevant groups and impact assessments. There must be tailored communication, a building of trust, and high-quality data about how groups are impacted.

57. The Inquiry has heard that work is now being done by the Welsh Government to make improvements to the content of the Public Health Wales's Emergency Response Plan in respect of inequalities. CBFJ Cymru feels strongly that all pandemic policy and plans must reflect the likely unequal impact of a pandemic on different groups and pro-active planning must occur in line with that envisaged by Professor Fenton, Mr Bell and Ms Field as outlined above.

58. CBFJ Cymru further notes that Professor Marmot was commissioned by the UK Government to carry out a strategic review of health inequalities in England which resulted in The Marmot Review.[107] The review summarised the evidence on the causes of health inequalities and made recommendations as to how to reduce them. Professor Marmot was further commissioned to produce a follow-up review in February 2020.[108] The Inquiry has heard that Scotland convened its own review and that Professor Marmot served on the advisory board.[109] The evidence is that no such similar review has been carried out in Wales.[110] CBFJ Cymru considers that a comparable independent review in respect of inequalities in Wales should be completed in order to inform planning moving forward.

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[106] Professor Kevin Fenton Transcript 5 July 2023 pp 89-90
[107] INQ000120840
[108] INQ000180278
[109] Professor Sir Michael Marmot Transcript 16 June 2023 p 7
[110] Ibid. pp 7-8

59. Finally, it has long been recognised by the Welsh Government that Wales has a higher proportion of older people than the rest of the United Kingdom and that as we age, we are more likely to develop chronic conditions and become frail.[111] In Sir Frank Atherton, Chief Medical Officer for Wales's Annual Report dated June 2022 he notes that over the next 20 years Wales is set to continue on its trend toward an ageing population, with the number of those aged 65 and over expected to increase from 21% of the population to 26.5%. The Report further cites the National Survey for Wales 2021 which highlighted that 46% of adults generally and 65% of adults over 65 report having at least one long-standing illness.[112] With these statistics in mind, it is crucially important that the approach to planning demonstrates that the needs of these groups are understood and incorporated into planning and response mechanisms.

Intergovernmental Communication

60. The lack of a holistic systemic approach in Wales was exacerbated by poor inter-governmental communications between Wales and the UK Government.

61. The Inquiry has heard that such communications were not working well. Mr Vaughan Gething gave evidence that the UK ministers and officials did not take the devolved administrations seriously, and that strained ministerial relations hampered pandemic preparedness.[113] Mr Drakeford, First Minister, also gave evidence that relations between Wales and Westminster did not work well,[114] but that there had been an improvement since 2022.[115] As to the relationships between officials, both said that these were better than at ministerial level.[116] It is extremely disappointing for the bereaved families to hear of communication issues between politicians that could have negatively impacted on their ability to do the work that they were entrusted to do to protect people in Wales.

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[111] CMO Frank Atherton Annual Report 2016-17, titled Gambling with our Health, dated 1 January 2018 (INQ000066188) p 8
[112] Annual Report from the Chief Medical Officer for Wales titled "Restoring our Health", dated 16 June 2022 (INQ000048783) p 10
[113] Mr Vaughan Gething MS Transcript 4 July 2023 t pp 121-124
[114] Mr Mark Drakeford MS Transcript 4 July 2023 p 199
[115] Ibid. Transcript p 203
[116] Ibid. pp 121-124 and 199

62. The Inquiry has heard about the new framework now in place, following the Review of Intergovernmental Relations dated January 2022.[117] This produced a new framework for collaborative working between the UK Government and the Devolved Governments with several tiers and a secretariat. In addition, specifically in relation to resilience issues, the UK Government Resilience Framework, December 2022[118] states at para 92 "*In order to maximise cooperation on a four nations basis, there will be periodic ministerial level meetings on resilience, informed by quarterly senior official quad meetings and regular official-level contact, as part of a joint governance process*".

63. What has apparently been a poorly functioning and hit-or-miss informal system of intergovernmental communication should now be replaced by a coherent system and all those politicians involved must consider themselves duty-bound to those whom the represent in relation to matters as important as planning for the next pandemic to ensure that it works effectively. The functionality of these new systems and protocols should be monitored periodically. Module 2 will cast further light on this important area. It is to be noted that the Welsh Local Government Association has included as one of its recommendations that there should be a commitment and prioritisation at both UK and Welsh Government level to protocols and agreements for consistent intergovernmental planning and co-decision-making.[119]

Access to scientific advice

64. At a UK-wide level, the Scientific Advisory Group for Emergencies ('SAGE') provides scientific and technical advice to support governmental decision-making during emergencies. Mr Mark Drakeford, First Minister, suggested that at the outset of the pandemic there was a lack of clarity surrounding ground rules for participation in SAGE and what work the devolved nations could commission from SAGE.[120]

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[117] INQ000102928
[118] INQ000097685
[119] Mr Chris Llewelyn para 205 INQ000177802
[120] Mr Mark Drakeford MS para 21 (INQ000177804)

65. The New and Emerging Respiratory Virus Threats Advisory Group ('NERVTAG') advises on the threat posed by new and emerging viruses. It was identified that weaknesses of NERVTAG include i) that it focuses solely on respiratory transmission;[121] and ii) focuses solely on present continuing emerging viral threats.[122] In this regard, NERVTAG should consider non-respiratory forms of transmission, should consider threats which "*may look small at the moment but could expand very significantly*".[123] and, as further suggested by Professor Sir Chris Whitty, should not confine itself to matters upon which the government has sought advice.

66. Wales had 'observer' status on NERVTAG.[124] From the evidence, it was unclear as to whether there had been at all times a firm channel of communication between all relevant parts of the Welsh Government and NERVTAG and clarity as to Wales's role on it.[125] Dr Quentin Sandifer expressed the view that it would be beneficial for Public Health Wales to have representation on NERVTAG.[126]

67. Wales had its own Chief Scientific Advisor for Wales, a Chief Scientific Officer in NHS Wales, a Chief Scientific Adviser for Health sitting within the Health and Social Services Group. In addition, Wales had a Scientific and Technical Advice Cell ('STAC') whose purpose was to try and ensure that, whilst needing to rely on of course advice, science and advice and use the networks at the UK level, that there may well be areas and there were experiences that showed that there was a need to translate advice directly into the Welsh context.[127] CBFJ Cymru considers that it remains unclear how STAC differs from the Technical Advisory Group ('TAG') and Technical Advisory Cell ('TAC'). It is particularly telling that Frank Atherton was not familiar with STAC.[128]

68. During the pandemic, TAG and TAC were established. Within his evidence, Sir Frank Atherton agreed that it became apparent when the pandemic struck that because the SAGE arrangement is a UK arrangement, there was a need within the Welsh

[121] Professor Sir Chris Whitty, Transcript 22 June 2023, pp 69-70
[122] Ibid. p 72
[123] Ibid. p 71
[124] Dr Andrew Goodall No. 2 para 170 (INQ000184901)
[125] Sir Frank Atherton, Transcript 3 July 2023, p 14
[126] Dr Quentin Sandifer Transcript 4 July 2023, p 68
[127] Dr Andrew Goodall Transcript 3 July 2023, pp 106-107
[128] Sir Frank Atherton Transcript 3 July 2023, pp 17-19

Government for tailored scientific advice to be given to Welsh Ministers therefore the Welsh Government set up TAG and TAC to carry out modelling with regard to Wales.[129] When asked why this third level of new body was required, Dr Goodall stated "*So Welsh Government had an observer status on SAGE, I know that changed over time and during the pandemic, which was helpful in clarifying some of the responsibilities. We did end up converting this arrangement into the technical advice arrangements in Wales through the pandemic response, and I do believe that that allowed us to understand the discharge of responsibilities in the Welsh context, not to recreate all of the SAGE mechanisms but to allow us to just simply translate the implications of that into the Welsh context, including the data and the evidence*".[130]

69. CBFJ Cymru considers there was evidence of a lack of clarity as regards the parameters of the mechanisms for co-operation to ensure adequate sharing of scientific information and expertise available to the Welsh Government from UK wide bodies, and that there must be clear and firm lines of communication so that Wales has the full benefit of scientific thinking at all times to inform preparedness, not just during an emergency.

70. Further, in respect of all scientific advisory functions, whether UK-wide or sitting within the devolved nations, scientific advice must be transparent and open to scrutiny and potential challenge, in line with the perspective set out in the following evidence given to the Inquiry: "*what we have in this country is a very open press, and very extensive and respected academia where there are lots of dissident voices, and I think that if the SAGE advice to ministers had been in the public domain earlier in the pandemic, I think there would have been lots of constructive criticism from academic organisations, universities up and down the country saying, "Have we thought about this? Have we thought about that?", which could have informed SAGE's thinking*".[131]

Lessons Learned

[129] Ibid. p 16
[130] Dr Andrew Goodall Transcript 3 July 2023, pp 108-109
[131] Mr Jeremy Hunt, Transcript 21 June 2023, p 179

71. CBFJ Cymru endorses the conclusion of Professors Mann and Alexander that there is a need for a radical shift to put in "*place a single, integrated and professional civil protection system which is fit for the future we face and capable of providing an effective whole system, whole of society response to emergencies on a catastrophic scale, as well as being able to tackle emergencies at local or regional levels*".[132]

72. CBFJ Cymru considers that for Wales, this means a system reflective of Welsh data, and Welsh risk assessment, supplemented by clear and meaningful arrangements for intergovernmental information sharing and working, and a clear and robust infrastructure for decision-making and leadership across the whole of government on this issue.

73. Science must play a central role in the system and the following key points are made in this regard:

    a. As Sir Jeremy Farrar described in his evidence, scientific infrastructure must be maintained as if it is not, then the UK but specifically Wales will be woefully underprepared to deal with tomorrow's inevitable pandemics.[133]
    b. There must be a mechanism to promote a two-way dialogue between government decision-makers and scientific advisors so that the focus of research and advice on both i) matters upon which government decision-makers have sought advice; and ii) proactive research and the provision of advice on matters which government decision-makers have not sought advice but which are of consequence and require potential political intervention.
    c. There should be formal representation of the devolved nations on UK-wide bodies such as SAGE and NERVTAG.
    d. In Wales, there is a need for streamlining and clarification in respect of the responsibilities of scientific advice bodies with a clear mechanism for the communication of information between the various functions within Wales and between Welsh and UK-wide functions.

[132] INQ000203349 p 185
[133] Sir Oliver Letwin Transcript 20 June 2023, p 21

e. Scientific advice must be readily available to all decision-makers in a timely way and, there must be clear two-way lines of communication in respect of information to and from the various advisory functions.
f. Scientific advice must be transparent and liable to challenge. Safeguards are required to ensure that the science is less liable to Group think, less closed and more open to scrutiny and challenge.
g. There must be clear audit trails demonstrating how the science has informed political decision-making.

74. Structures for decision-making on pandemic preparedness and response in Wales are not fit for purpose as outlined earlier in these submissions. The following key changes are required:

a. Clear leadership on resilience and preparedness. Sir Oliver Letwin[134] stated his view that at a UK level a Senior Cabinet Minister devoted solely to the resilience and preparedness portfolio should be appointed. CBFJ Cymru considers that such a function is equally important for Wales. Whilst in Wales, this function has traditionally been carried out by the First Minister, as Mr Reg Kilpatrick acknowledged within his evidence,[135] the appointment of a dedicated minister for resilience and preparedness could provide a greater impetus in the day-to-day work of preparedness and resilience. CBFJ Cymru say that this work is crucial and ought to be the subject of a dedicated Welsh Minister portfolio.
b. Clarity and streamlining of the preparedness and resilience structures in Wales together with an updating and harmonisation of plans in order to ensure, as Mr Reg Kilpatrick acknowledged in his evidence that there was a need for,[136] that the system works as a coherent whole rather than as a set of plans.
c. A Wales Risk Register.[137] Naturally this will look to the UK wide National Risk Register but the Welsh Government should apply its mind to and own its own centralised risk assessment.

[134] Sir Oliver Letwin Transcript 20 June 2023, p 4
[135] Mr Reg Kilpatrick Transcript 6 July 2023, p 122
[136] Ibid, p 136
[137] Ibid, pp 131-132

d. Senior Ministers and key personnel must be adequately trained in crisis management.[138]

e. A robust assurance framework to make sure that policies and guidance on preparedness actually result in the action being taken on the ground to put arrangements that they stipulate in place and are tested for their effectiveness.

75. Ultimately, the success of any radical shift can only be ensured if there is accountability, support and strong leadership by the Welsh Government. In this regard, CBFJ Cymru has continuously called on the Welsh Government to acknowledge its failures and take responsibility for them. Without such accountability, lessons will not be learned and when the next pandemic arrives many more Welsh lives could be lost. CBFJ Cymru remains concerned in respect of the Welsh Government's acceptance of failings to date and its commitment to long-term pandemic planning. Its concerns have been fuelled by the brevity of some key Welsh Government witness statements; and often only limited or qualified acknowledgment of errors.

76. The Welsh Government must now reflect on the evidence which this Inquiry has heard, acknowledge its failures and provide a strong commitment to the systemic change required to prevent future loss of life.

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RLR

2.8.23

[138] Ibid. p 152

BEFORE BARONESS HEATHER HALLETT

IN THE MATTER OF: THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

CLOSING STATEMENT

ON BEHALF OF COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU

MODULE 2

Introduction

1. CBFJ Cymru is dedicated to campaigning for truth, justice and accountability for the bereaved in Wales. Its members have experienced first-hand failures to respond adequately to the pandemic in Wales and the UK as a whole, and the catastrophic effects of those failures. The group seeks answers about what happened in Wales and why decisions which impacted on Wales were made in the way they were, so that there can be true accountability and lessons learned.

2. The pandemic response in Wales was primarily the responsibility of the Welsh Government, acting under its devolved responsibilities, and it primarily must be accountable for that response. However the UK Government (UKG)'s decisions and UK level structures also shaped the response in Wales.

3. In the period leading to the first national lockdown Welsh Government decisions were aligned with UKG decisions. All Four Nations sat on COBR and agreed the Coronavirus Action Plan of 3 March 2020 and full national lockdown on 23 March 2020. How decisions relating to Wales were made will be examined further in Module 2B, but we know that after 23 March 2020, at times, Wales adopted the same policy as UKG's policy applicable to England, although at times with later implementation in Wales (e.g. testing of all individuals discharged from hospital to a care homes ; whole care home testing), and at other times policies were different, for example, the switch from *Stay at Home* to *Stay Alert* in May 2020 was not adopted in Wales, and in Wales there was an Autumn firebreak. The main financial levers were at the UKG level (although there is a debate as to the extent Wales was given more flexibility during

the pandemic). SAGE was the main source for scientific advice and information UK-wide including for Wales.

4. Against this background, a central concern for the Welsh bereaved families in this module is whether the UK Government and the Welsh and other Devolved Administrations collaborated effectively.

5. This statement considers the evidence in Module 2 on areas of UKG decision-making and UK structures where these shaped or are relevant to understanding the response across the UK including in Wales, under the following headings:

Preparedness (its relevance to this module)
Inequalities
The initial response to Covid-19
Asymptomatic transmission
Social care
Airborne nature of the virus
After the first national lockdown
Internal border issues
Intergovernmental relations (UK Government and the Devolved Administrations)
Public announcements and messaging
The sharing of UK science expertise throughout the UK

Relevance of preparedness in Module 2

6. The lack of preparedness of the UK for a pandemic (the subject matter of Module 1) is a key matter of context for the subject matter in this Module. Two significant aspects relevant across the UK were: the lack of an overarching plan for a pandemic response such as this and the lack of a scalable infrastructure for testing and for test and trace.

7. It was stated in the evidence, that had the public health infrastructure in the UK been as developed as in some other countries, other paths and outcomes may have been open to the UK[1]. Professor Hale's report states that the most effective governments were able to minimize the use of stringent measures by relying on effective systems

[1] Second witness statement of Sir Patrick Vallance, dated 14/08/2023 [INQ000238826/100]

for test, trace and isolate and that such strategies are particularly effective when combined with fast, stringent - but limited - NPIs when an outbreak escapes such a system[2]. The Royal Society's report (August 2023) assessing the effectiveness of NPIs during the pandemic says 25 studies illustrated that test, trace and isolate is "*a powerful tool for reducing transmission.*"[3]

8. The UK did not have this infrastructure, which could have given it a better chance of a response that would cause less harm. Professor Sir Christopher Whitty includes in his lessons the weakness in capacity to scale-up in testing and contact tracing. This, he points out, requires investment in advance[4]. This must be one of the key lessons for the future.

The extent to which regard was had to inequalities

9. The Inquiry was right to include in this Module an examination of the regard had to vulnerable and at risk groups including whether appropriate regard was had to pre-existing inequalities including structural racism. Of first importance is Sir Patrick Vallance's written and oral evidence stating that it was entirely foreseeable that pre-existing structural and health inequalities within ethnic minority and other vulnerable groups would result in disparities in risk and outcome[5]. He made the following important point for policy makers in any future pandemic: "*this is an historically true statement, that pandemics differentially affect the most disadvantaged and they drive further disadvantage and inequality*" and that "*it is something that policy makers needed to take into account*" (Transcript 22/174/18-22/175/1). The evidence to the Inquiry shows not enough regard was had to these foreseeable disparities, in the planning during the time of the emerging threat and after the pandemic struck.

10. The treatment of and attitudes towards the frail older population have been issues of concern to CBFJ Cymru. In the group's opening statement to Module 2, it asked if the older population were a cohort who were overlooked by the UKG, whether they were seen as lesser, or dispensable. The first point arising from the evidence is that this

[2] Report by Professor Thomas Hale, titled 'Expert Report for the UK Covid-19 Public Inquiry - Module 2: Oxford COVID-19 Government Response Tracker Evidence for UK Covid-19 Inquiry', dated 22/08/2023 [INQ000257925/14]
[3] Report titled Covid-19: examining the effectiveness of non-pharmaceutical interventions from the Royal Society, dated 24 August 2023 [INQ000250983/35]
[4] Fourth Witness Statement of Professor Sir Christopher Whitty, dated 22/08/2023 [INQ000251645/231]
[5] Second witness statement of Sir Patrick Vallance, dated 14/08/2023 [INQ000238826/180] para 552; Transcript 22/174/8-12

cohort were sometimes spoken about by the then Prime Minister in a way that suggested they were dispensable: "…*there will be more casualties but so be it they have had a good innings.*"[6]; "*Why are we destroying everything for people who will die anyway soon. – Bed blockers*"[7].

11. Further, the evidence to the Inquiry regarding policies relating to social care and the care home population showed in core decision-making an alarming lack of an effective response to the known vulnerability of frail older people resident in care homes to respiratory disease outbreak. See further on this subject in a separate section below.

12. Public messaging was lacking as regards addressing the needs of ethnic minority groups. Professor Whitty's observations were that, for specific ethnic minority communities, public health messaging was not done effectively at the beginning of the pandemic and, in his view, arguably, could have done better throughout (Transcript 24/123/14 - 24/124/8).

13. There were deficiencies in data gathering where disparities needed to be addressed. Ade Adeyemi, healthcare professional and general secretary of Federation of Ethnic Minority Healthcare Organisations (FEMHO), gave evidence of a lack of a systematic and urgent gathering of data where there was evidence that the pandemic was having a disproportionate impact on ethnic minority healthcare workers, and that groups of ethnic minority healthcare workers had to do their own data collection and information gathering (on top of their normal jobs) because they did not see such data being gathered or did not see it being acted on. The important point was made: if the data is not gathered you don't know what steps should be taken (Transcript 4/95/22 – 4/98/1).

14. Inadequacy in provision of PPE had disproportionate impact on ethnic minorities: there was evidence of ethnic minority healthcare workers feeling unable to raise issues with ill-fitting PPE because of power imbalances in the workplace or, if they did, were not listened to; evidence was submitted to the Women and Equalities Committee that 64% of BAME doctors reported feeling pressured to work in settings with inadequate PPE (Ade Adeyemi, Transcript 4/106/3 – 4/108/24).

[6] Inquiry Legal Team Chronological List of Key Extracts from Sir Patrick Vallance's Notebooks, dated between January 2020 and February 2022 [INQ000273901/245]
[7] Record in notebook of Imran Shafi [INQ000146636/92]; Transcript 31/128/10-22 – 31/129/1-22

15. As regards the foreseeable increase in risk of domestic violence during lockdown, action could and should have been taken early as soon as the potential for stay at home measures were anticipated but the response was slow and not comprehensive enough. When questions were put to Dame Priti Patel, Secretary of State for the Home Department throughout the relevant period, the upshot was that there was no evidence of substantive steps taken by the Home Office to protect those who would be put at increased risk of domestic abuse as a result of lockdown until 26 March 2023, 3 days into the national lockdown (Transcript 21/173/17 – 21/177/17). The lockdown regulations appeared to lack an exception to the rules to allow friends or relatives to provide refuge to a person fleeing domestic abuse (Transcript 30/100/4-19). The lack of sufficient serious thought to the foreseeable harm and how it could be mitigated was demonstrated by the fact that key public announcements about the lockdown restrictions were made by the UKG without mention of the exception from the requirement to stay at home for those needing to escape domestic abuse until January 2021 when the exception "*or to escape domestic abuse*" was stated (Transcript 32/185/22 – 32/188/12).

16. The Inquiry is asked to note the important evidence about how decision-making should be approached in order to effectively address and take into account inequalities and disparity in impact. The Inquiry heard evidence about the importance of proper consultation of those impacted and the value of co-design in making policy that addresses inequalities. As highlighted by the Disabled People's Organizations (Transcript 20/152/2 – 20/153/20 & 34/93/14-34/94/25), there should be proper consultation, not just consultation by representatives of disabled people in set piece meetings, but consultation should bring those who are actually affected by decisions into the room. In this context, the evidence of Lord Mark Sedwill, (Cabinet Secretary June 2018 - September 2020), also should be noted: that any good policy process should involve engagement with representative groups, particularly in these circumstances groups of the most vulnerable in society, and he too endorsed co-design, as resulting in better policy (Transcript 20/153/2-20).

17. There was evidence on the importance of the range of experiences that inform decisions and how this was lacking at the centre of government: "*Across the advice and discussions there was a striking absence of humanity or perspective about people or families or how people actually lived….policy advice was often impractical about the realities of how people actually live (e.g. that everyone would have a separate bathroom that an infected person could use)*", was the evidence of Helen MacNamara

(Deputy Cabinet Secretary January 2019 - February 2021). It was her evidence that there was a serious lack of thinking about domestic abuse and the vulnerable, about carers and informal networks for how people look after each other in families and communities, the impact on single parents of some of the restrictions, guidance for women who might be pregnant. She described a "*systematic failure to think outside the narrow perspective of the people involved in decision making.*"[8].

18. The above evidence was compelling in showing the need for greater diversity as to who is in the room when discussions are being had and decisions made, and for meaningful consultation with those who are affected by decisions.

19. The above paragraphs touch on only a few of the important aspects of the evidence on inequalities, essential to understanding the impact of the pandemic and evaluating the response to it. The issues will be further examined in relation to Wales in Module 2B.

The initial response to Covid-19

20. As to the early period of the response to the pandemic, the evidence showed fundamental problems in the decisions, actions and inactions at UKG level. The Welsh Government was closely tied into the response at UKG level in this period, so the evidence provides insight into the response in Wales too.

21. The UKG response lacked a sense of urgency; it lacked a plan and a strategy. The lack of a strategy impacted on how science advice could be provided: evidence was given to the Inquiry that throughout 2020, SAGE suffered from having little sense of what the high level strategic objectives of the Government were in managing the crisis and that, had it known, it may have reached conclusions about the need to adopt the policies that it ultimately advised faster[9]. It was Professor Sir Chris Whitty's evidence that sometimes the Government was waiting for SAGE to take a strategic position, so there was a potential circularity (Transcript 23/69/1-14).

22. The lack of a due sense of urgency was striking in the evidence as to the position as at 4 February 2020. It was known at this time there was a possibility of a pandemic,

[8] Witness statement of Helen MacNamara, dated 09/10/2023 [INQ000273841/52-54]
[9] Second Witness Statement of Professor Neil Ferguson, dated 11/07/2023 [INQ000248854/7]

and it was reasonable to assume that, if there was, there would be between 100,000 and 300,000 deaths (Professor Whitty's evidence (Transcript 23/162/18-23/163/3)). By this time the WHO had declared a public health emergency of international concern, COBR had met, and the advice was being given by SAGE. It was Professor Whitty's evidence however that at this time the Government was not "*electrified*" (which he attributed to a systemic attitude to natural hazards) and that, had it been, then this would have led to "*a stronger all-of-government think-through of all the potential consequentials*" (Transcript 23/164/22-24).

23. It is clear from the above evidence, we submit, that the state of affairs as early as 4 February 2020 was such that the UKG should have gone into a completely different gear: the UK was facing the possibility of many thousands of deaths; the UKG should have been "*electrified*" at that point, but it was not.

24. There was evidence of over confidence at the centre of government, and this was noted to be particularly strong in the Prime Minister's morning meetings – "*we were going to be world-beating at conquering Covid-19 as well as everything else*" (observations of Helen MacNamara) and this "*supreme confidence*" and the idea that the Italians were overacting was evident as late even as early March 2020.[10]

25. It was not until 2 March 2020 that the Prime Minister took the Chair of COBR. It was not until early March 2020 that the crisis shifted to become a whole-government effort (Matt Hancock, Transcript 29/19/9-11).

26. There was confusion about the extent to which herd immunity (from people becoming infected by the virus) formed part of the actual strategy the Government was pursuing. When asked about whether the Government promoted herd immunity as a goal, Professor Whitty responded that communications gave the impression it was pursuing a policy (of herd immunity) which it "*absolutely was not pursuing*" (see the evidence of Professor Whitty, Transcript 24/22/5-19). This was then, we submit, at the very least, a major failing of communication about what was or was not the strategy.

27. The only overarching plan for a pandemic response prior to 3 March 2020 was the 2011 pandemic flu plan which was aimed at managing the consequences of a flu pandemic, not stopping a virus from spreading; it was based on the wrong doctrine. It

[10] Witness statement of Helen MacNamara, dated 09/10/2023 [INQ000273841/15-16]

was a doctrine that led to identifying how many body bags would be needed rather than focusing on how to stop people becoming ill in the first place. Evidence has been heard about a tabletop exercise, Exercise Nimbus, in February 2020 – that this was based on the doctrine of the 2011 pandemic flu plan. Consequently, the exercise was directed, not at what could be done to counter the spread of the virus, but how to prioritize patients in the event of the NHS becoming overwhelmed (Matt Hancock, Transcript 29/105/12 – 29/106/16). Mr Hancock, the then Secretary of State for Health and Social Care, stated that, with hindsight, the exercise should have been about at what point to lock down, how much data was needed before making a decision, what NPIs were going to put in place and in what order, how do you save lives in the least damaging way and "*not are we going to find enough mortuary space and who should decide on prioritization of NHS treatment*" (Transcript 29/103/22 – 29/104/11). CBFJ Cymru submits, this is not just a matter of hindsight but a failure to focus adequately on what should have been focused on: what was actually needed to counter the emerging threat of the virus and to prevent people from becoming ill and dying.

28. The "*Coronavirus: action plan - A guide to what you can expect across the UK*", a Four nations' document, published 3 March 2020[11], set out an approach, but was less than a plan for action. References to action points to counter the threat of widescale spread of the virus were oblique (see page 18 of the plan), and it was short on action points[12]. The Action Plan overstated the extent of other existing plans in place (see page 8 of the plan).

29. As at mid-March 2020 the seriousness of the situation remained still not fully understood within the UKG: see the evidence of Professor Whitty, that by mid-March still not everyone in Government/the Downing Street machinery realized that the situation was heading in a very difficult direction and conceptualized how quite low numbers of cases through exponential growth would turn into very large numbers in an extremely short period of time because of the doubling time (Transcript 24/5/20 – 25/6/23); and Professor Dame Angela McClean (current UKG Chief Scientific Adviser (GCSA); Chief Scientific Advisor for the Ministry of Defence, acting deputy GCSA and SAGE participant during the pandemic) : "*in the first few weeks of March 2020, I began*

[11] Report from the UK Government titled Coronavirus: action plan - A guide to what you can expect across the UK, dated 03/03/2020 [INQ000182380]
[12] Discussed at 29/137/23-29/138/2

to feel that there did not seem to be a plan within government, or a clear sense of how many people were going to die."[13]

30. The Inquiry should find, as has been accepted in the evidence of Boris Johnson[14], that mass gatherings should have been banned earlier. The decision by the UKG was not to advise to ban mass gatherings until 16 March 2020, the same approach being adopted by the Welsh Government. By 12 March 2020, other countries could be seen to be banning mass gatherings and the number of cases was in the thousands and growing[15] CBFJ Cymru members say people in Wales recognized the threat and this was demonstrated by the fact that already by this time in Wales hand-gel was scarce to buy. The politicians whose job it was to make the decisions should have thought more widely than just the scientific advice about relative risks and taken account of a wider context at that time.

31. Evidence was heard from Sir Patrick Vallance that on 13 March 2020 information was received which "*unambiguously showed that the pandemic was far more widespread and far bigger and moving faster than we had anticipated*" from a number of sources, including surveillance systems, and that over that weekend it became very clear that much more stringent measures would be needed to control the virus and they needed to be introduced quickly. This was the view of Sir Patrick Vallance and of SAGE which was made known to the Prime Minister and which led to the decision on 16 March 2020 to introduce the voluntary measures to reduce contacts which preceded the eventual decision for a mandatory lockdown on 23 March 2023 (Transcript, 22/45/4 - 7).

32. This statement does not seek to identify the earlier point when the first national lockdown, which was necessary and unavoidable, should have been imposed, about which much evidence has been heard[16], but submits that the evidence overall clearly shows that information emerging throughout February and into early March 2020 about the growing threat of the virus was not responded to by the UKG with the focus and speed that the seriousness of the situation demanded; and this meant opportunities were missed to do vital planning for measures (large and smaller scale)

[13] Witness statement of Professor Dame Angela McLean , dated 19/10/2023 [INQ000309529/34]
[14] Boris Johnson, Transcript 31/118/20-23
[15] Witness statement of Sir Partrick Vallance, dated 14 August 2023, INQ000238826/194; COBR meeting minutes for 11 March 2020 INQ000056220/2
[16] For example, Professor Sir Chris Whitty, 23/56/9-13 and 23/58/9-13; Sir Patrick Vallance, 22/44/20-21; 22/50/4-8; 22/118/11-12; Sir Jonathan Van-Tam, 25/54/9-15; Dame Angela McClean, 25/54/9-15

to prevent people from catching the virus, and to try to minimize the potential harms that the larger interventions that were necessary would cause.

Asymptomatic transmission

33. CBFJ Cymru are deeply concerned by the evidence of how the risk of asymptomatic transmission was not factored into decision-making and the implications this is shown to have had. This subject is likely to have played out in similar ways in Wales as at the UKG level and in England because of the shared science and similarity in policies.

34. It is very clear in the evidence that, although uncertain, the risk of asymptomatic transmission was known early on. The minutes of the SAGE meeting of 28 January 2020 state, "*There is limited evidence of asymptomatic transmission, but early indications imply some is occurring. PHE developing a paper on this.*"[17] It was recorded in SAGE minutes of 4 February 2020 that "*asymptomatic transmission cannot be ruled out*".[18] NERVTAG meeting minutes for 21 February 2020 record the following comment on evidence from Singapore, South Korea and Japan – "*the evidence suggests that 40% of virologically confirmed cases are asymptomatic*"[19]. There was further discussion at the SAGE meeting on 27 February 2020 of the possible extent of asymptomatic transmission: Transcript, 18/136/17-20.

35. By the end of February 2020, evidence available from the outbreak on the Diamond Princess cruise ship was said to have "certainly *strengthened the principle that asymptomatic transmission was occurring*" (Professor Sir Chris Whitty, Transcript 23/181/13-14).

36. How it came to be the case that the possibility that the virus may be transmissible asymptomatically did not inform important decision-making in relation to people who were particularly vulnerable to the virus, given the potential for catastrophic consequences if the virus was spread to them, is impossible to comprehend. It was known from January 2020 that care home residents were some of the most vulnerable to Covid-19, acknowledged by the then Secretary of State for health and Social Care in his witness statement[20]. Hospital discharge to a care home gives rise to a specific

[17] Minutes of SAGE meeting 2, dated 28/01/2020 [INQ000057492]
[18] Minutes of fourth SAGE meeting, dated 04/02/2020 [INQ000051925/3]
[19] Minutes of NERVTAG, 21 February 2020 [INQ000119469/6] para 3.4
[20] Witness statement of Matt Hancock [INQ000232194/10] para 40

risk arising from the nature of the 2 environments: "*hospital discharge to care homes connects 2 high-contact environments.*"[21]

Policies relating to hospital discharge to care homes failing to address asymptomatic transmission

37. Decisions made in late March and early April 2020 in relation to hospital discharge and consequent admission to care homes did not factor in the risk of asymptomatic transmission. The policy decision was made for swift discharge from hospitals in the 19 March 2020 document "*Covid-19 Hospital Discharge Service Requirements*"[22] published by HM Government and the NHS, an instruction directed to hospitals and social care staff in England. The stated purpose was to free up at least 15,000 beds within a week of implementation and maintain discharge flows after that. Patients were to be discharged from hospital as soon as they were clinically safe to be discharged. There was no provision for the testing of symptomless patients prior to discharge to care homes, tests being limited and prioritized in accordance with a list of priorities. The issue arises not from the fact of discharge from hospital of those who no longer needed to be there but from the fact that when the UKG was driving forward such a policy that involved some of those discharged being admitted from hospital to care homes there was an absence of consideration of the impact on other care home residents of asymptomatic cases.

38. It has been established in the *Gardner* case brought in 2022 (*R (Gardner) v Secretary of State for Health and Social Care (1) NHS England (2) and Public Health England* (3)[2022] EWHC 967 (Admin); [2022] PTSR 1338) that the UKG (through its Department of Health and Social Care) failed to take into account asymptomatic transmission when it should have in relation to the consequences for care home residents of the 19 March 2020 hospital discharge policy. In the *Gardner* case, that policy and the related NHS document "*Next Steps on NHS Response to COVID-19*"[23] were subject to challenge by daughters of 2 former care home residents who died in the first wave of Covid-19. Also the subject of challenge was "*Admission and Care of Residents during Covid-19 Incident in a Care Home*", 2 April 2020 (published by the DHSC, PHE and others)[24]. The 2 April 2020 document acknowledged that some

[21] Technical report on the Covid-19 pandemic in the UK, dated 01/12/2022 [INQ000203933/299]
[22] Guidance from NHS titled Covid-19 Hospital Discharge Service Requirements dated 19/3/2020 [INQ000087450]
[23] [INQ000087317]
[24] [INQ000233798]

patients discharged from hospital or admitted from a home setting may have Covid-19, whether symptomatic or asymptomatic but nevertheless (inexplicably) advised that if an individual had no Covid-19 symptoms care should be provided as normal. The court found against the Department of Health and Social Care and PHE, not on the basis that discharging patients from hospital who no longer had a need to be in hospital was in error, but on the basis of the failure to take into account the risk to elderly and vulnerable residents from asymptomatic transmission: that those drafting the March Discharge Policy and the April Admissions guidance "*simply failed to take into account the highly relevant consideration of the risk to elderly and vulnerable residents from asymptomatic transmission*"(paragraphs 287-9 of the judgment). The court did not accept that nothing could have been done to mitigate the risk, finding that the 19 March 2020 document could, for example, have said that where an asymptomatic patient (other than one that has tested negative) is admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for up to 14 days. However, the matter had simply not been addressed. The court made its findings against the DHSC and PHE because it was those bodies that bore responsibility for making arrangements for people admitted to care homes (paragraph 296 of the judgment).

39. On any view, this system for health and social care was not working rationally in publishing a policy directing discharge of untested individuals to care homes full of residents who were highly vulnerable to the disease without giving proper thought to how that would affect other residents and what should and could be done to address the issue. It is not an answer to say that it was right to discharge from hospital people who no longer needed to be in hospital. As to the response on this issue from the then Secretary of State for Health and Social Care, Matt Hancock, when asked about the hospital discharge policy, he referred to the finding in the *Gardner* case that to discharge individuals from hospital was in itself reasonable and appeared to misunderstand or ignore the full findings in the case (Transcript 30/38/20 – 30/39/15) - that there had been a failure to address the implications of such discharge given the risk of asymptomatic transmission in care homes.

40. The reasons Matt Hancock gave in his evidence to the Inquiry as to why the risk that there might be asymptomatic transmission was not factored into decision-making sooner than it was cannot be considered satisfactory or reasonable, given that the possibility of asymptomatic transmission was known and given what the potential consequences would be. Mr Hancock gave the reasons that the scientific advice from

the WHO until April 2020 was that there was no asymptomatic transmission; that he could not overrule what he referred to as a global scientific consensus; and that the advice from PHE to him was based on this global advice. He stated that the US Centre for Disease Control (CDC) published a study on 3 April 2020 demonstrating that asymptomatic transmission was likely to be occurring, that it was after that that he instructed PHE to review "all of our guidance", but that before that point, it had been decided to act on the CDC evidence. As regards the change of position by mid-April 2020, he said as regards that point in time, that as "*we were ramping up testing*", on 15 April it was decided that all patients being discharged from hospital into care homes should be tested and this was extended to asymptomatic care home staff on 28 April 2020.[25] It is not reasonable that such rigid thresholds were applied as to what should be taken into account in decision-making given what the state of knowledge on asymptomatic transmission actually was well before 3 April (see paragraphs 34-35 above).

41. Whilst the CMOs' technical report (2022) says that the epidemiological and genetic evidence suggests hospital discharge does not appear to have been the dominant way in which Covid-19 entered most care homes, it also states: "*some care homes outbreaks were introduced or intensified by discharges from hospital.*"[26] This report makes the important point: that hospital discharge to care homes should remain a high priority for preventative actions in similar pandemics.

Policy response to movement of staff between care homes too late because of failure to take account of asymptomatic transmission

42. It should have been noted early on that care home staff were a source of transmission of a virus into care homes because, even when symptomatic, care home staff might continue to work. The Inquiry has been referred to the article which Professor Sir Jonathan Van Tam co-authored in 2017 highlighting the risk of introduction of a virus by care home staff and the vulnerability of the sector. This article states, "*Long-term care facility environments and the vulnerability of their residents provide a setting conducive to the rapid spread of influenza virus or other respiratory pathogens. Infections may be introduced by staff, visitors or new or transferred residents*". It

[25] Witness Statement of Matt Hancock, dated 03/08/2023 [INQ000232194/82-84]
[26] Technical report on the Covid-19 pandemic in the UK, dated 01/12/2022 [INQ000203933/298]

highlights the issue that healthcare workers "*often continue to work despite having symptoms and may act as a source of infection to those in their care.*"[27]

43. It was not however until 15 May 2020 that the UKG introduced an advisory policy and funding to support the reduction in the movement of care home staff between care homes and there was further guidance in June 2020.[28] The Inquiry heard evidence from the then Secretary of State for Health and Social Care Matt Hancock as to the reasons why a policy to support reducing the movement of care home staff between different care homes was not put in place earlier than 15 May 2020 (when questioned by the TUC on this): "*Until we had clear advice on asymptomatic transmission following the CDC publication on 3 April, the advice was that, as I said, that if you were symptomatic and therefore didn't go to work if you were symptomatic, then that was essentially enough to address the problem, compare - given the known negatives of restricting the workforce*." (Transcript 30/114/12-18). Mr Hancock gave evidence of the importance and effectiveness of the policy that was introduced on 15 May 2020: that it "*reduced infection significantly*" and that this is "*a vital lesson for future pandemics – and indeed for normal times – that staff movement between care homes should be limited.*"[29]

44. We submit, a comprehensive policy response in relation to care homes that took account of the possibility of asymptomatic transmission via staff moving between high contact environments should have been in place much earlier in the pandemic, given the risks that were or should have been already known or at least identified in the period between January and March 2020 when the threat was emerging. The need to have acted earlier and more comprehensively in relation to this known vulnerable population is demonstrated clearly by the evidence: by mid to late April 2020, over 25 per cent of care homes had declared a Covid-19 outbreak and infection rates in care homes were considered to be higher than in the general community.[30]

45. The UKG (through its Department for Health and Social Care or otherwise) should have applied a precautionary approach where there was uncertainty as to the evidence on asymptomatic transmission, when dealing with highly vulnerable care

[27] Article published on Wiley titled 'Influenza in long-term care facilities', dated 27/06/2017 [INQ000269388/1-3]
[28] Witness Statement of Matt Hancock, Member of Parliament for West Suffolk, dated 04/10/2023 [INQ000273833/8-9]
[29] Witness Statement of Matt Hancock, Member of Parliament for West Suffolk, dated 03/08/2023 [INQ000232194/12]
[30] Ibid [INQ000232194/84]

home populations. Lessons must be learned from the way the system for health and social care failed to do what it was supposed to do – to protect vulnerable people – in the most fundamental way – and about how a risk that was uncertain, but one that has potential for devastating consequences, should be taken into account in the decisions that concern very vulnerable people. The issues will be returned to in the context of Wales in Module 2B because Wales adopted a similar hospital discharge policy to the one considered in this module and will have needed take account of asymptomatic transmission in relation to care homes and generally.

Social Care

46. Social care will be looked at in a separate module and this is a devolved area which will be examined in Module 2B. However, in addition to the points made above about the impact on the care home sector of the failure to factor in asymptomatic infection at an early stage, the following points about the response to the pandemic in social care are worthy of mention here, being particularly telling of the lack of early decisions to anticipate the needs of this sector:

(i) The written evidence of Helen Whately, the then Minister for Social Care in the Department for Health and Social Care, was that she was warned about the risk that lack of sick pay could lead to care home staff working despite having Covid-19 and therefore she wanted to make sure staff received their normal wages from day one of isolation, coupled with clear guidance on when to isolate. This, she says, was implemented in early June 2020.[31] The Inquiry should find that, given that the need for such a policy was predictable, this step should have been taken earlier.

(ii) The problems with getting key data should be noted. Helen Whately states she asked officials to provide her with figures for care home deaths, but she could not get timely accurate data on Covid-19 deaths in social care in stark contrast to deaths data from NHS hospitals. She first received reliable figures in April 2020.[32]

(iii) Professor Dame Jenny Harries, the then Deputy CMO for England, when giving her evidence, was asked about an email exchange in which she responded on 16 March 2020 to a question from a representative of the Department for Health and Social Care about what the approach should be to hospital discharge of

[31] Witness statement of Helen Whately, Minister of State (Minister for Social Care) in DHSC, dated 30/10/2023 [INQ000273897/46]
[32] Ibid [INQ000273897/14-15]

symptomatic individuals to care homes. In response Dame Jenny Harries had stated her predictions that: "*Whilst the prospect is perhaps what none of us would wish to plan for I believe the reality will be that we will need to discharge Covid-19 patients into residential care settings…This will be entirely clinically appropriate because NHS will triage those to retain in acute settings who can benefit from that sector's care. The numbers of people with the disease will rise sharply within a fairly short timeframe and I suspect make this fairly normal practice and more acceptable but I do recognize that families and care homes will not welcome this in the initial phase.*"[33] Dame Jenny Harries said in her oral evidence that this was a high-level view and an attempt to explain what the size of the problem might be (Transcript 28/8/3 – 28/16/6). The Inquiry is asked to note the risk to those in care homes that was being contemplated (in this email exchange) and that the comments are telling of shockingly low expectations as to what provision social care would therefore be making for this highly vulnerable cohort.

(iv) The evidence showed decision-making at a national level to be fragmented and unnecessarily complex. The Department for Health and Social Care is responsible for national policy in relation to social care[34], but national funding to the sector does not go through that department but through a different department namely the MHCLG: see the evidence of Matt Hancock, where he referred to having needed to use an "*unprecedented*" route for getting funding for the social care sector fast in March 2020, namely via the NHS, "*and when we took the proposal to Number 10, they said, 'We're in favour but you need to make sure that Treasury and MHCLG are supportive of using this approach, because it's novel'* " and , "*We invented new ways of getting money to care homes, in the same way that we gave free PPE where all the time in the past PPE had been bought by the care homes themselves*" (Transcript 30/48/9-17). This structure for decision-making in social care – requiring resort to routes that were considered novel and unprecedented to get urgent things done in a pandemic – was obviously very unsatisfactory.

Airborne transmission

47. In CBFJ Cymru's opening statement the group invited the Inquiry to examine whether enough was done to factor in the airborne nature of the virus. The way modes of transmission of the virus were understood and acted on at UKG level is likely to be

[33] Email of Professor Dame Jenny Harries to the Director for Adult Social Care, DHSC, dated 16/03/2020 [INQ000151606/1]
[34] Third Witness Statement of Sir Christopher Stephen Wormald, on behalf of Department of Health and Social Care, dated 29/03/2023 [INQ000144792/3]

relevant to understanding the approach adopted across the UK including the approach taken by the Devolved Administrations.

48. Several routes of transmission were recognized early as possible routes of transmission. There was scientific debate about the relative importance of each[35]. Early acknowledgement that airborne/aerosol transmission may be possible is seen in the document "Review of data on persistence of SARS-COV-2 in the environment and potential infection risk", 14 February 2020, p 2: "*airborne/aerosol transmission may be possible, particularly following aerosol generating procedures and events*", which also states "*preventing transmission of infectious virus in aerosols requires FFP3 respiratory protection*"[36] . It was stated by Professor Sir Chris Whitty, the scientific general view has shifted to consider suspended aerosol as being of more importance (a greater proportion) than was originally thought.[37] This, in turn, Professor Whitty says, led to a greater emphasis on the role of ventilation and he gives an example of a UKG public information TV advertisement in November 2020 which encouraged opening windows and using extractor fans.[38]

49. A specific sub-group of SAGE, the Environmental Modelling Group (EMG), was formed in mid-April 2020 to look at how the virus transmits, and also to look at local mitigations (not the "big tickets" like lockdown) but things like ventilation and face masks. (See Transcript 13/3/15-13/4/16.)

50. Professor Catherine Noakes, Professor of Environmental Engineering (who leads research into ventilation, indoor air quality and infection control in the built environment[39]) was the convenor and chair of the EMG. She gave evidence that it was her view that the aerosol transmission routes were being overlooked and that there was evidence upon which to operate according to a precautionary principle from January 2020. She stated that, although the evidence on aerosol transmission at the outset was weak, the evidence was weak for all transmission routes, and that on a precautionary basis it would have been appropriate to indicate that aspects like

[35] Witness Statement of Professor Sir Christopher Whitty, dated 15/08/2023 [INQ000248853/100]
[36] Guidance from Guidance Cell titled Review of data on persistence of SARS-CoV-2 in the environment and potential infection risk, to Public Health England internal / NERVTAG review, dated 14/02/2020 [INQ000047771/2]
[37] Witness Statement of Professor Sir Christopher Whitty, dated 15/08/2023 [INQ000248853/100]
[38] TV advertisement from HM Government and NHS, regarding protective measures dated 18/11/2020
[39] Rule 9 Questionnaire Response from Professor Catherine Noakes, [INQ000056505/2]

ventilation mattered early on and as the evidence base increased that people should have been made more aware of the relevant mitigations for aerosol transmission (Transcript 13/17/10 – 13/18/5).

51. The evidence showed that public information on this issue was deficient even in Autumn 2020 and later. Professor Noakes's evidence was: information on the websites of PHE and the NHS for members of the public - who may be trying to find information about how to manage the illness – as late as September 2020 was still focused on droplets and surfaces and did not mention airborne transmission. This caused Professor Noakes to email Professors Vallance and Whitty to express her concerns that the evidence base she had been collecting, discussing and agreeing was not feeding into these guidelines. The NHS did not change the information until June 2021 (Transcript 13/18/13 – 13/19/16).

52. The important point was highlighted by Professor Noakes that "*many buildings including a large proportion of hospitals do not meet current design standards particularly for ventilation rates*". She also highlighted an absence of engineering expertise at a strategic level for example in Infection Prevention and Control guidance where aspects around ventilation "*often receive scant attention in IPC documents*". She says it is "*critical that guidance for front line healthcare staff also includes information on how to manage ventilation and which devices/approaches to use when. I hope that one of the lessons from the pandemic can be the better joining up of engineering, microbiological and behavioural expertise to improve infection control strategies in healthcare and other buildings*".[40]

53. The importance of the continued development of learning on modes of transmission was also highlighted by Professor Noakes. The Government funded a £21 million National Core Study on Transmission and the Environment (PROTECT) which ran between early summer 2020 and 2023, after recognizing the lack of robust data on transmission. This has developed new capacity and capability to be able to measure and model transmission of respiratory infection which Professor Noakes said she hopes will be beneficial for future pandemics, but she said there were no firm plans to retain its capacity and no strategic investment for this. She said, the impact of the

[40] Witness Statement of Professor Noakes, [INQ000236261/4-5]

PROTECT study would have been greater had the learning it generated been present to a greater extent sooner. [41]

54. The Inquiry received written evidence from Dr Philip Banfield, Chair of the BMA's UK Council: referring to the need for: greater focus on indoor ventilation, a recommendation to meet outside where possible; FFP2/3 respirators available to vulnerable people as offering better protection from infection than ordinary masks, and the need for clearer public health messaging on this issue.[42]

55. The contention that there should have been greater focus on more effective mask wearing is supported by the findings in the Royal Society Report (August 2023), which are based on evidence from researchers around the world: that as regards mask wearing there was a "*gradient of effectiveness*" with evidence, mainly from studies in healthcare settings, that higher quality N95/FFP2 masks were more effective than surgical-type masks.[43] Sir Mark Walport, in his oral evidence, noted the importance of the gradient shown by the studies: "*importantly there was a gradient. In other words, respirator masks were more effective than surgical masks…the plausibility of the results was emphasized by that gradient effect. In other words you might expect that a very – you know, the sort of masks that you'd wear in a – if you're exposed to a dangerous toxin is much more likely to be effective than a loosely fitting mask*" (Transcript 7/120/17 – 7/121/3).

56. When Covid-19 was de-classified as a High Consequence Infectious Disease on 19 March 2020, this meant the loss of the requirements that status carried for certain PPE to be worn in relation to the care of patients, amongst other things, FFP3 respirators[44]. The Minutes of the NERVTAG meeting of 6 March 2020 show that already due to shortage of stock of FFP3 masks, guidance was changed so that healthcare workers treating suspected cases would wear surgical facemasks only and not an FFP3 respirator.[45] Dame Jenny Harries, when asked about whether cost played a part in decisions on the provision of FFP3 masks, said it did not but that at times there was difficulty in procuring them (Transcript 28/66/22 – 28/67/13), but this issue

[41] Witness Statement of Professor Noakes, [INQ000236261/72]
[42] Witness Statement of Professor Philip Banfield on behalf of the British Medical Association, dated 21/07/2023 [INQ000228384/36-37]
[43] Report titled Covid-19: examining the effectiveness of non-pharmaceutical interventions from the Royal Society, dated 24 August 2023 [INQ000250983/60]
[44] Third Witness Statement of Sir Christopher Stephen Wormald, on behalf of Department of Health and Social Care, dated 29/03/2023 [INQ000144792/66 and 208]
[45] Minutes of NERVTAG meeting 8, dated 06/03/2020 [INQ000087540/3]

has not been explored in detail in Module 2 and it is hoped will be looked at in more detail in Module 3. The evidence of Dr Philp Banfield was that current IPC guidance still does not require healthcare professionals to have access to "*PPE (such as FFP3 respirators)*" when dealing with Covid-positive or suspected positive Covid cases outside of when undertaking a limited range of aerosol generating procedures.[46]

57. On the evidence the Inquiry has received, it is submitted, the following point made in the witness statement of Dr Banfield is shown to be well-founded and the Inquiry is asked to find accordingly: "*a key failure of the Government was and continues to be the failure properly to acknowledge (and at an early enough stage) that Covid-19 was spread by aerosol transmission, and to adapt their public messaging, guidance to health services or the focus of their NPIs appropriately*".[47]

58. When it comes to Module 3 (on health), CBFJ Cymru considers the Inquiry must look in detail at and get to the bottom of how decisions have been made on FFP3 masks for healthcare workers across the UK treating Covid-19 cases.

59. CBFJ Cymru believes the seriousness of airborne infection is still not appreciated and acted on in Wales. This is relevant in many settings including in hospitals. CBFJ Cymru wishes the Inquiry to make recommendations at speed about responding to the airborne nature of the virus.

After the first national lockdown

60. CBFJ Cymru believes that the need to understand and provide up to date information about all the possible smaller scale countermeasures and mitigations was particularly pertinent at the time when the UK was coming out of the first national lockdown and afterwards. There should have been focus on identifying the fullest range of effective mitigations – on an individual, organization and workplace level, such as ventilation and appropriate mask wearing. The evidence in this module suggests there was not enough focus on these types of measures.

61. In this regard, a number of practical points about design, information and communication in relation to mitigating measures, made by Professor Noakes[48], are

[46] Witness Statement provided by Professor Philip Banfield on behalf of the British Medical Association, dated 21/07/2023 [INQ000228384/47]
[47] Ibid [INQ000228384/36-37]
[48] Witness Statement of Professor Noakes [INQ000236261/4, 17-18, 60-61 &70-71]

very pertinent, and provide important insights for future public health crisis responses. Her written evidence contained the following:

(i) There was a gap around dealing with the slowly changing evidence base. Officials would ask for evidence relating to a particular mitigation measure and having received this once it was rare that the question was asked again. This meant that guidance or the actions taken by an organization could sometimes be based on out-of-date evidence. A periodic check question of "*has anything changed*" would have been useful.

(ii) There is clearly a challenge in ensuring that updated evidence is effectively disseminated to those who need to act on it. By late 2021 large numbers of businesses were not following approaches that were supported by evidence. Many were still implementing significant surface hygiene measures but not implementing ventilation measures which were likely to be more important.

(iii) Guidance was issued by multiple different Government departments which could have some discrepancies. This can create a difficulty in particular for organizations that come under a range of different departments.

(iv) It is important, in Professor Noakes's view, to help the public to understand scientific evidence around transmission. Measures such as ventilation, distancing, face covering etc. were given limited explanation. The podium speeches could have been an opportunity to explain in more detail why these measures were likely to work. Professor Noakes believes that people are more likely to comply with measures if they understand how the virus spreads and therefore why actions they are being asked to do are likely to be effective.

(v) A large number of organizations in the engineering sector proposed technology solutions during the pandemic (new mask and respirator designs, air cleaning technologies for buildings, sensors for measuring and monitoring contact between people, technologies for cleaning surfaces). Whereas some were well designed and effective, others were ineffective, addressed the wrong questions or in some cases harmful. Professor Noakes stated that a need exists for higher standards and regulation for many of these technology solutions as well as a greater expectation of integrity in the sector to ensure approaches that work and are safe.

62. Turning to Eat Out to Help Out (EOTHO), CBFJ Cymru believes that the policy – which actually encouraged people to get together indoors – was the wrong way to decide to boost the economy at that time. It was not a responsible decision for the UKG to

make, to actively encourage indoor gatherings when people still needed to take precautions against an airborne virus. The failure to consult scientific opinion was poor practice and irresponsible. Boris Johnson stated in his witness statement, "*it was properly discussed, including with Chris and Patrick….Of course we considered the implications for infection, but we thought that this could and would be mitigated by the social distancing requirement still in force and it was very important to balance that against damage to the economy*"[49]. However, it is now known that a careful consideration and balancing of the weight of competing factors cannot have taken place, given that, in fact, as is now clear from hearing the evidence of Professor Sir Chris Whitty and Sir Patrick Vallance, they were not consulted about EOTHO, and Mr Johnson had merely assumed the proposal had been discussed with them (Transcript 24/63/1-24/64/2; 22/95/3 and 32/10/13-15). Mr Sunak's position on giving evidence was simply that those who had concerns "*had ample opportunity to raise these concerns between the announcement of the scheme and its implementation*" in fora that met at that time (Transcript 33/124/21-23).

63. EOTHO was a policy that extended to Wales. There was no suggestion in evidence in this module that the Welsh Government objected to it at the time. The position the Welsh Government took with regards to EOTHO and the reasons for it will be further considered in Module 2B.

64. The Autumn firebreak in Wales started on 23 October 2020, lasting 17 days. This was implemented over a month after it was advised by SAGE. The Inquiry has heard evidence from Professor Dame Angela McClean that measures should have been taken in September. She said that, while it was better than nothing, it did not cause a great decrease in cases (Transcript 24/113/6-24). England's lockdown, starting shortly later, lasted 4 weeks. Why the decisions on the Welsh Autumn firebreak were made in the way they were and whether it was effective will be further considered in Module 2B.

65. This module included evidence on the UKG's decisions on funding for Wales during the pandemic. The evidence in Module 2 provided two very contrasting pictures of what those funding arrangements amounted to. The evidence of Mark Drakeford, First Minister for Wales, in his first witness statement for this Module was that Rishi Sunak, the Chancellor of the Exchequer at the time, refused funding to support the

[49] Witness statement of Boris Johnson [INQ000255836/119]

Welsh Autumn firebreak, that this was misguided and meant the Treasury was acting as a Treasury for England only, because funds were extended to Wales only when a similar set of measures were introduced in England, and that had the Welsh Government had the confidence that the UKG would provide the money needed to support people during firebreak they probably would have implemented that lockdown earlier[50].

66. These criticisms were rejected by Mr Sunak on giving his evidence to the Inquiry. His evidence was that additional money was provided to the Devolved Administrations including Wales by way of an upfront funding guarantee in July 2020 and that this was uplifted on three occasions most notably on 9 October 2020, shortly before the Welsh firebreak, that the upfront funding guarantee was an unprecedented payment of money in advance, which provided flexibility outside of the Barnett formula for the Devolved Administrations to respond to the pandemic; and how they spent the money was a matter for them (Transcript 33/168/18-33/169/9 & 33/171/8 – 33/172/3) . There is likely to be further evidence to come in later modules including Module 2B on whether the upfront funding guarantee did provide an appropriate degree of flexibility in a public health crisis and whether or not Mark Drakeford's criticisms can be substantiated given what has been said by Rishi Sunak as to flexibilities and money provided.

Internal Border issues

67. One of the areas of difference between UKG and the Welsh Government in the latter part of 2020 was that Welsh Government wanted the UKG to take stronger action (to legislate not just issue guidance) to prevent people travelling from high incidence areas in England into low incidence areas in Wales potentially spreading the virus well beyond their locality. The Prime Minister Boris Johnson did not agree to this, stating that to legislate would be too resource intensive and that the guidance was clear[51]. No agreement was reached, and the Prime Minister wrote to Mark Drakeford on 15 October 2020, "*I deeply regret your announcement yesterday that you intend to legislate to prevent people from other parts of the UK travelling into Wales*" referencing that evidence as to potential impact was not clear and proposing continued dialogue to better understand the latest data and impact on the border region in particular[52].

[50] Witness Statement of Mark Drakeford, dated 14 September 2023 [INQ000273747/40-41]
[51] Ibid [INQ000273747/39] paras 132 and 134
[52] Letter from Boris Johnson to Mark Drakeford, 15 October 2020 [INQ000216550/2]

68. It may well be that there was no bridging this difference of opinion as to the correct approach, and that any different structure for decision making for UKG and Devolved Administrations (in respect of which, see further below) would not have been avoided the disagreement. This subject may be further considered in Module 2B.

69. Martin Hewitt of the National Police Chiefs' Council (NPCC) gave evidence about policing border areas: *"We had relatively limited challenges with Scotland because of the nature of the geography. With Wales there were more challenges with different regulations, different sides of what is essentially an invisible border, and that was very challenging I think for particularly a number of the Welsh forces and the English forces, where you had -- where you had different regulations either side of a road*" (Transcript, 21/47/23-21/48/6).

70. The evidence on these issues demonstrates why it was important that UKG and Devolved Governments should work together to minimize differences in the response as far as possible, and the importance of having suitable structures in place to give the best chance of working together and reaching agreement where possible; also that where there were unresolved differences, clarity of communications about which rules applied where was important (see further below on this subject).

Intergovernmental relations

71. Turning to how the UKG worked with the Welsh Government and other Devolved Administrations: CBFJ Cymru believes that the UK and Devolved Governments should have worked more closely together with a single aim of providing the most effective response they could to the pandemic across the whole of the UK.

72. How relations were conducted between UK and Devolved Governments mattered in order to have the best chance of reaching agreement on policies across the Four Nations, and where policies were different so that they could consider the implications for each other of their different policies and co-ordinate implementation and public announcements. In sum, co-ordination between nations would lead to a more effective response and better chance of saving lives.

73. In his written evidence to the Inquiry, Mark Drakeford, First Minister for Wales, referred to the UKG making announcements without notice to devolved governments. He said that when that happened it prevented the Welsh Government from having prepared a parallel announcement for Wales and led to avoidable uncertainties for the population when a policy was seen to be introduced in England with no equivalent for Wales.[53] For example the announcement of changes of policy on mandatory face coverings on public transport, on facemasks in NHS facilities, and on bubbling for single person households, which, he said in a letter to Michael Gove in June 2020, had big practical implications for Wales, but there was minimal or no prior communication[54].

74. In the evidence before the Inquiry there is frequent reference to a "*Four Nations approach*", used to signify not just the Four Nations acting uniformly but also flexibility for nations to adopt different policies whilst coordinating with each other. There are plenty of examples of ministers inviting and endorsing a Four Nations approach. The question should be addressed however: However did the UKG and Welsh Government do all they reasonably could to promote a Four Nations approach?

75. At the health minister level, the Inquiry heard evidence that the health ministers of the Devolved Nations met with Matt Hancock by regular Four Nations health minister telephone calls and shared a WhatsApp group. Mr Hancock said this filled a gap where there had been "*a missing piece of institutional architecture*" and worked well. He commended the other health secretaries for their approach saying they "*left politics at the door*" and he referred to substantive matters where there were tensions being resolved in a professional and business-like manner (Transcript 30/56/15 - 30/58/10). There will be further evidence in Module 2B on the Welsh perspective on these meetings.

76. There was regular close engagement throughout the pandemic between the four CMOs of the Four Nations. There was much evidence about how constructive these engagements were, for example the evidence of Professor Sir Chris Whitty (Transcript 23/35/13-23/39/21).

77. The question must be asked why, despite all the evidence of positive engagement at these levels, and when the core science was the same, were there still so many differences between policies in England and Wales that were not avoided –

[53] Witness Statement of Mark Drakeford, dated 14/09/2023 [INQ000273747/21]
[54] Letter from Mark Drakeford to Michael Gove, dated 11/06/2020 [INQ000216519]

differences as regards timing relating to mask wearing and testing or other differences in the plethora of rules after coming out of the first lockdown. The issue will be looked at further in Module 2B as to why Wales did things differently: whether it was lack of communication or delay in implementation or were there other reasons.

78. The position at the Prime Minister and First Minister level must also be considered. It is notable that Boris Johnson in his evidence made several statements to the effect that the relationship was good with the Welsh Government/Devolved Administrations and that there was more that united the UKG with the Devolved Administrations than divided them (Transcript 32/109/4-10 and 32/118/12-13). But Mr Drakeford pointed in his evidence to significant problems in the structure of the relationship at Prime Minister and First Minister level during the pandemic. He wrote to the Prime Minister asking for a more collaborative approach[55].

79. In the initial phase of the pandemic, COBR was convened regularly, providing a forum for meeting at the Prime Minister and First Minister level. However after 10 May 2020 the UKG decided that COBR would cease to meet regularly, and it did not meet at all between 10 May and 22 September 2020. This meant that the Four Nations having gone into lockdown together, when they were taking the careful steps out of lockdown, COBR was not meeting. At that stage and from then onwards there were more differences in policies between UKG and Welsh Government.

80. The Inquiry has heard that at that time it was suggested to the then Prime Minister Boris Johnson, by Helen MacNamara, that he convene the Joint Ministerial Committee (JMC) as a means of engagement with the First Ministers (Transcript 16/99/19 – 16/100/19). This was a structure specifically for meetings between UKG and Devolved Administrations, but no JMC was convened. Instead, it was decided, with the support of Dominic Cummings, that the First Ministers were to have regular calls with Michael Gove, the then Chancellor of the Duchy of Lancaster (Transcript 15/122/8-15/123/21).

81. The Inquiry has heard evidence that it was considered that Mr Gove did a skillful job in his conduct of regular meetings with the First Ministers, but this arrangement meant that the Devolved Administrations' First Ministers did not have direct contact with the Prime Minister on a regular or predictable basis. There was, as put by Mark Drakeford

[55] Witness Statement of Mark Drakeford, dated 14/09/2023 [INQ000273747/31]

in his witness statements, a lack of a "*regular rhythm of engagement*"; a lack of "*regular checkpoints that only the Prime Minister could provide*"; a "*vacuum*" at the final pan government level.[56]

82. The Inquiry has received the evidence of Boris Johnson orally and in his witness statement as to his reasons for making these arrangements in the way he did - that it was his view that it was "*optically wrong*" for the prime minister to meet with the Devolved Administration First Ministers "*as though the UK were a kind of mini EU of four nations*"[57]; he referred to wanting to avoid "*the risk of pointless political friction and grandstanding because of the well-known opposition of some of the [devolved administrations] to the government – and also to avoid unnecessary leaks"* (Transcript 32/121/16-20).

83. These were not good reasons. Mr Gove's evidence on leaks should be noted: that "*it is most important to have the right people in the room*"[58] and that "*overall in the greater scheme of things that that was not a particularly significant concern*" (Transcript 27/170/23-24). Boris Johnson's reasons for not meeting more regularly with the First Ministers of the Devolved Administrations betray a lack of commitment to serious and grown-up attempts to work with the Devolved Administrations. His own personal view of the "*optics"* of engaging with them should not have come into it: he was the Prime Minister for the whole of the UK in a public health crisis.

84. That there was a wrong mindset in operation in parts of the centre of UKG when it came to working with the Devolved Administrations is also evident from Dominic Cummings' evidence: that he thought Mr Gove would "*handle the process of dealing with the DAs*" better and that, generally speaking, the Prime Minister talking to the Devolved Administrations "*did not advance any cause*". (Transcript 15/122/13 – 15/123/14).

85. Dominic Raab in his witness statement said he found "*it became irritating as the pandemic went on that Scotland and Wales wanted to do things slightly differently or with different timings for what appeared to be political reasons.*"[59] When asked to identify an example he did not identify one (but said he was just giving his impression

[56] Supplementary witness statement from Mark Drakeford, dated 21/09/2023 [INQ000280190/6-9]
[57] Witness Statement of Boris Johnson, dated 31/08/2023 [INQ000255836/44]
[58] Second Witness Statement of Michael Gove, dated 1 September 2023 [INQ000259848/80]
[59] Witness Statement of Dominic Raab, dated 08/09/2023 [INQ000268041/66]

holistically) (Transcript, 28/237/18 – 28/238/24). It should be noted that there is a clear inconsistency in on the one hand criticizing the Devolved Administrations for not "*aligning*" with the UK, while at the same time denying them access to the decision-making process.

86. Mr Gove, in his evidence, suggested there was a case for overriding devolution when it came to a pandemic which affected Great Britain, and that, whilst issues such as "*how much fruit to eat and so on"* were *"quite properly a matter for devolved administrations*", such a pandemic would not be (Transcript 27/116/13-22). This however would be contradicting the approach taken by the Four Nations on going into the pandemic, which was on the footing of the devolved nations' existing respective responsibilities in public health.

87. The Inquiry has seen the record of a meeting on 22 April 2020 between Michael Gove and the Secretary of States for the Territorial Offices, which was called following Mark Drakeford's request for weekly meeting between the First Ministers and UKG ministers and a weekly COBR.[60] As mentioned, the arrangement that was put in place for intergovernmental relations during the pandemic was not in accordance with what Mr Drakeford requested, but instead the arrangement was for regular meetings with Michael Gove. The record of the meeting on 22 April 2020 contains several entries that show the discussion of what the arrangements for intergovernmental relations should be was informed at least in part by suspicion and fear of political advantage on the part of some of those present: there were references to a "*temptation for DAs to jockey for position*"; to an option being preferable as it would be "*easier to handle Scottish FM*"; "*Drakeford's request is positioning himself for the next year's Assembly elections*"; one of the Secretary of States reasons included that he was "*nervous of excluding DAs*"; Michael Gove summed up that he'd heard the Secretary of States' caution that *"regular meetings should be a potential federalist Trojan horse*"; it was said, "*DAs are dispersed in wider UKG meetings; if we convene them in a smaller meeting, they may prove more difficult to handle*"; and this was a "*fair point about handling the DAs*".

88. The tenor of the discussion clearly suggests the wrong mindset towards interactions with the Devolved Administrations in parts of the UKG - not a genuinely serious and grown-up attempt to find the best way of working together. It also strongly points to

[60] Email dated 22 April 2022 [INQ000091348/1-2]

the need for proper agreed structures for intergovernmental relations to be in place in advance of any future crisis.

Public announcements and messaging for the Four Nations

89. Clarity of public announcements and messaging of course was very important during the pandemic. Where the Four Nations were not all following the same policy there obviously needed to be as much clarity as possible about what applied where - for the sake of the most effective response to the pandemic. The evidence shows that UKG did not apply commitment to that goal.

90. Professor Henderson reported: "*an analysis of the text of prepared speeches throughout 2020 shows that those speaking on behalf of the UK government did an incomplete job of outlining the territorial scope of their data, information or guidance…..There was little attempt to outline what applied UK-wide and what applied only to England."* and press briefings repeatedly failed to clarify that new rules in a whole range of areas were England-specific, from school closures to rail networks to retail. [61]

91. The handling by the UKG of its messaging when it switched from *Stay at Home* to *Stay Alert* from 10 May 2020 is telling of the lack of a plan to be clear about when the message for England did not apply in the DAs. The then Prime Minister Boris Johnson was aware that the DAs did not want to change their messages (they wished to take a more cautious approach out of Lockdown). Mr Johnson said at COBR on 10 May that the UKG would de-conflict where necessary[62]. When he was asked when giving his oral evidence what "*de-conflict where necessary*" amounted to and whether the UKG took all steps it could sensibly take to be clear that the change of message did not apply to the Devolved Nations, he did not provide an answer about what actual steps were taken in this regard (Transcript 32/124/10 – 32/130/18). It is to be inferred that there was no or little by way of a plan that took proper account of the fact that the DAs' message remained *Stay at Home*.

92. See also the evidence of Lee Cain, Director of Communications for the UKG, where his answers on the issue of the way communications were managed in relation to the

[61] Report by Professor Ailsa Henderson, Devolution and the UK's Response to Covid-19 [INQ000269372/49-50]
[62] Record of call between Michael Gove and the 3 First Ministers, 8 May 2020 [INQ000256846]; "Readout from COBRA 10/5" [INQ000216537/3]

switch to *Stay Alert* (Transcript 15/48/13 – 15/52/3), it is submitted, also imply the lack any proper plan to distinguish between the messaging applicable to England and messaging applicable to the Devolved Administrations.

93. See also Alex Thomas's report: reporting that in the 10 May 2020 address the Prime Minister announced an initial easing of restrictions but did not once make the point that it applied in England only[63].

94. UK media also contributed to the confusion by failing to state when public health messages did not apply in the territories of the Devolved Administrations. Professor Henderson commented on this in her report[64].

95. These errors were avoidable.

Structures for sharing science expertise and advice throughout the UK

96. As regards how SAGE provided its expertise on a UK wide basis - the following observations are made:
    (i) the Devolved Administrations' participation on SAGE was regarded as providing a valuable contribution (Transcript 22/163/10-12 & 24/101/9-13).
    (ii) DAs were invited to attend SAGE from SAGE No. 6 (Transcript 8/46/5-8); they should be invited from the outset. This appears to be accepted (Transcript 24/100/15-20).
    (iii) Scientific papers received by SAGE should be made available to the DAs. There was a delay in making them available. (Transcript 24/101/15 – 24/105/5).
    (iv) As regards SAGE sub-groups and NERVTAG, the evidence in the report of Professor Henderson[65] is that more than half the SAGE sub-groups did not have representation on them from Devolved Administrations.
    (v) As regards modelling, a lack of data from nations other than England was said to have been "*a difficult issue for quite some time*" making it difficult for SPI-M to do work specifically relevant to the Devolved Administrations (evidence of

[63] Report titled Political and administrative decision making in relation to the Covid-19 pandemic, Alex Thomas [INQ000236243/39]
[64] Report on Devolution and the UK's Response to Covid-19, Ailsa Henderson [INQ000269372/49]
[65] Report of Professor Ailsa Henderson, titled 'Devolution and the UK's Response to Covid-19', dated 07/09/2023 [INQ000269372/33-34]

Professor Dame Angela McClean (Transcript 25/36/2-5), however this got better over time. Professor Graham Medley (Transcript 8/91/21 – 8/92/5) said a "*kind of modelling unit for Wales*" was formed and he attended the Technical Advisory Group (TAG) meetings in Wales to help ensure coherence in modelling.

97. In sum, the evidence suggests the trend on SAGE and its sub-groups was towards greater embracing of the needs of and co-working with the Welsh Devolved Administration. These areas, the extent to which Wales did its own modelling, and the subject of presence on committees (whether as participant or observer) including NERVTAG, are likely to be examined further in Module 2B, and CBFJ Cymru will make further observations in light of the further evidence in Module 2B.

Findings and recommendations

98. When considering its findings and recommendations, the Inquiry is asked to take into account the evidence highlighted and observations made in the above paragraphs of this statement.

99. The sub-paragraphs below set out the main points arising from this statement relevant to recommendations for the future (with references to the relevant paragraphs of this statement):

Intergovernmental relations (Paras 71-88)

(i) The recently reformed system for intergovernmental relations between UKG and the Devolved Administrations should include structures suitable for a prolonged period of crisis. During the pandemic, a formal structure for regular meetings at Prime Minister and First Minister level *plus* the calls with Michael Gove would have been a better arrangement.

(ii) Intergovernmental relations should be approached with the sole aim of collaborating to achieve the most effective response to the crisis.

(iii) The Four Nations should seek to reach agreement on measures where possible. Where they have not agreed on the same response, they should co-ordinate their respective actions. In any event notice should be given by any administration in advance of any major announcements so that other nations can consider the implications for each of them of their different policies.

Further observations will be made on intergovernmental relations during the pandemic and recommendations after hearing the evidence in Module 2B.

Four Nations public health communications (paras 89 – 95)

(iv) UKG should have a proper plan to be clear in all communications about which measures apply where in the UK and should do all it sensibly can to make clear when a measure applies only to England.

(v) UKG publications should state whether data is applicable to the whole of the UK or just to England.

(vi) The media should make clear when public health messages apply just to England and not to the whole of the UK.

Sharing of science expertise across Four Nations (paras 96-97)

(vii) UK-wide science advice and advice structures (SAGE and its sub-committees and NERVTAG) should continue to be accessible to Devolved Administrations. This should be strengthened by Devolved Administrations being invited from the outset to attend all key groups and committees (as participants or observers as appropriate) and further developing collaboration between UK and devolved science bodies.

Unequal impact – structural inequality

(viii) Policymaking in response to future pandemics should reflect from the outset the principle "*that pandemics differentially affect the most disadvantaged and they drive further disadvantage and inequality*", by measures that address the unequal impact. (Para 9)

(ix) It should be a priority at the outset to identify implications for those at risk of Domestic Violence and to put in measures to address the risk (Para 15)

(x) There should be systems for speedy data-gathering where disparity in impact is suspected but not yet fully recognized or addressed, to be able to identify what steps need to be taken to address those disparities. (Para 13)

(xi) Effective public health messaging to specific ethnic minority communities requires attention from the outset. (Para 12)

(xii) Policymakers need to properly consult the people impacted by inequalities, and policymaking to address inequalities should involve co-design and collaboration with the relevant groups who are impacted. (Paras 16 – 18)

Public health infrastructure (Paras 7 – 8)

(xiii) The public health infrastructure should have the capacity to be scaled up rapidly for mass testing and widescale test and trace.

Airborne transmission of the virus (Paras 47-59)

(xiv) The airborne nature of SARS-CoV-2 should be acknowledged and acted on. This includes infection prevention and control that will protect people in hospitals from aerosol transmission (including appropriate PPE and ventilation).

(xv) Non-compliance with design standards for ventilation in buildings should be addressed and greater attention paid to ventilation in infection prevention and control. (Para 52)

Understanding of modes of transmission of a virus

(xvi) The capacity and capability developed during the pandemic to measure and model transmission of respiratory infection should be retained, so that the learning is not lost and will be available at the outset when the next pandemic or similar public health crisis strikes. (Paras 47-50 and 53)

(xvii) In a future pandemic the public should be helped to understand the scientific evidence on transmission of a virus so that they can understand the reasons for the steps they are asked to take. In the pandemic, more detail should have been given in the podium speeches as to why the measures advised (such as ventilation, face masks) were likely to work, to increase the likelihood of compliance. (Para 61(iv))

Public information about low harm countermeasures

(xviii) Public health information and messaging should be informed by the up-to-date scientific knowledge about the nature of the virus/disease and steps that individuals can take as mitigations, so that the full range of relevant mitigations (including the smaller interventions that will do least harm – such as for example in this instance opening windows; appropriate mask wearing) can be brought into play as soon as possible. (Paras 60-61)

(xix) Information made available to the public about the virus (for example on NHS or other public body websites) and information disseminated to businesses

and other organizations should be kept up to date with the changing evidence base. (Para 51, 61(ii))

(xx) Guidance issued by different Government Departments should be consistent and discrepancies between guidance issued by different departments avoided. (Para 61 (iii))

Asymptomatic transmission

(xxi) The lessons must be learned from the failure in the first wave of the pandemic to take into account in decision-making the possibility of asymptomatic transmission, when the evidence was uncertain. Where an aspect of the nature of the virus is uncertain but could result in serious harm, policymakers should take a precautionary approach especially in policy affecting vulnerable people. (Paras 33-41)

Social care

Whilst this area will be examined in the future module on social care, the following may be relevant to core-decision making in Module 2/any interim recommendations:

(xxii) Future decision-making on hospital discharge must ensure that hospital discharge will not cause the spread of infection into care homes (Paras 37-41; 46(iii))

(xxiii) Future decision-making on care homes should take into account the known risk that care home staff can transmit the virus to residents. There should be effective policies to counter this risk. (Paras 42-44 and 46(i))

(xxiv) A review is needed of how central government provides urgent funding to the sector; a process shown to be unduly complex in the pandemic. (Paras 46 (iv))

(xxv) A review is needed of the availability of data on the sector. (Para 46 (ii))

Central Government's capability to respond

Since the pandemic the Resilience Framework has been published and its implementation has started, resulting in some changes already to structures in the UKG for crisis management. The new framework should be developed having regard to the following:

(xxvi) the need for a trigger for earlier involvement of the whole of government in responding to an emerging threat;

(xxvii) the need for a review of how politicians can more effectively engage with the science advice they seek;

(xxviii) decision-makers need to recognize when they need to draw on a wider range of life experiences when making decisions affecting huge numbers of people's lives in major ways and properly consult those affected (see paragraph (xii) above);

(xxix) the need for a structure for decision-making during a time of crisis that is geared to ensuring better and more coherent decision-making at the heart of Government to reduce the chances a descent to such chaotic decision-making such as was seen in the centre of government during the pandemic, (e.g. in relation to EOTHO the then Prime Minister assumed scientific opinion had been obtained but it had not.)

Long Covid

(xxx) The recommendations made on behalf of the Long Covid groups (Transcript 34/85/9-23) are adopted here: that the long-term health consequences of a novel virus should be planned for, identified, monitored, measured and factored into any response to a pandemic.

Concluding observations

100. This Module has shown that the UKG was only in part willing to accept the Devolved Administrations' role: the issue lay at the Prime Minister level, where despite some warm words by Boris Johson about the relationship there was suspicion and failure to embrace the task of working with the Devolved Administrations for the benefit of the UK as a whole. There should have been a close and grown-up collaboration – which people across the UK were entitled to expect. Whether the Welsh Government did all it should have done to collaborate must be considered in Module 2B.

101. The evidence in this Module shows that decision-makers and institutions of the UKG were not equal to the task of responding to the pandemic, with serious consequences across the UK. This Inquiry's recommendations are much needed, because these same errors must not be repeated when the next pandemic or other major public health crisis inevitably occurs.

CRAIG COURT

HARDING EVANS SOLICITORS

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12 JANUARY 2024

BEFORE BARONESS HEATHER HALLETT

IN THE MATTER OF: THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

CLOSING STATEMENT ON BEHALF OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU ('CBFJ CYMRU') - MODULE 2B

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1. CBFJ Cymru are a group of bereaved families who came together to campaign for truth, justice, and accountability for all those bereaved by Covid-19 in Wales, following the devastating loss of their loved ones in the most traumatic of circumstances. The Welsh Government (WG) ask the Inquiry to judge their actions based on what was reasonable at the time suggesting that "*to have taken one reasonable course when an alternative reasonable option was also available does not make the course taken wrong or in some way flawed*". However, CBFJ Cymru commend the approach taken in Counsel to the Inquiry (CTI)'s opening to judging decision making, namely that what must be scrutinised is whether the WG discharged its duty to protect the lives of the people in Wales which must be considered through probing and challenging the core decisions "*to see if they were made on the best information, after proper consultation, as part of a well ordered process, and without undue delay or unnecessary prevarication*". As stated by CTI in opening, "*if the protection of life is the pre-eminent duty which every government owes to its people, then the numbers of those who died is the marker against which the Welsh Government's response must be judged. This is the simple metric which matters most. Death was the inevitable consequence of a runaway high-consequence infectious disease and prevention of death should arguably have been the Welsh Government's primary obligation*".[1] As was confirmed in Professor Sir Ian Diamond's evidence, Wales's age-standardised mortality rate was on a par with England and was significantly higher than that of Scotland.[2] CBFJ Cymru are disappointed at the lack of accountability and failure to ensure proper record keeping regarding the use of WhatsApps for government business. WG was wrong to use informal communication during a national emergency and was wrong not to ensure that all communication was retained.

Early Response (January to March 2020)

2. WG's initial response was passive, slow and disjointed; characterised by sloth-like urgency where risk was misunderstood, national strategic leadership lacking and valuable time was lost in January – March 2020.
3. There were clear warnings from late January 2020 that what was happening internationally could soon happen in Wales. The CMO(W), Sir Frank Atherton, warned the First Minister by 24 January 2020 that "*there was a significant risk the virus would arrive in Wales*".[3] At the COBR meeting on 29 January 2020, attended by Mr. Vaughan Gething and Sir Frank, UKG confirmed its intention to prepare for the reasonable worst-case scenario (RWCS) which was similar to that of the pandemic influenza.[4] On 30 January 2020,

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[1] M2B Transcript [1/8/2-10]
[2] M2B Transcript [3/78/15-18]
[3] INQ000371209/23
[4] INQ000056226/5

the four UK CMOs formally increased the risk level from low to moderate,[5] (referred to in CTI's opening in Module 2 (M2)(1/30/13) and closing statement of the Office of the CMO[6]). A press release issued by WG on 31 January 2020, headed "*Statement from the Chief Medical officer for Wales about Coronavirus*", set out that "*the four UK Chief Medical Officers consider it prudent for governments and the NHS to escalate planning and preparation in case of a more widespread outbreak. For that reason, we are advising an increase of the UK risk level from low to moderate…. the UK should plan for all eventualities*" and "*It is likely that Wales will see cases of novel coronavirus*".[7] Mr. Gething in his witness statement acknowledges the increase in the risk level to moderate at that time.[8] An email received by Sir Frank from DHSC on 5 February 2020, notified him of Professor Sir Chris Whitty's words to Directors of Public Health on 31 January 2020: "*We are currently using pandemic flu for reasonable worst case scenario planning*" and "*planning for mitigation now is wise*".[9]

4. In the face of all these warnings, by the end of January/ very early February 2020, WG should have been electrified, but it is clear from the evidence that it was not. It is to be noted that flu pandemic RWCS planning assumptions in Wales were premised on 50% of the population experiencing symptoms of which 1-4 % would require hospital treatment, and 12,000-15,000 excess deaths in a 15-week wave.[10] The WG did not discuss Covid-19 in Cabinet until 25 February 2020, notwithstanding the implications of these planning assumptions. Mr. Drakeford's oral evidence on the reaction of WG to the virus in January - February 2020, amounted to informal discussions with Mr. Gething following COBR meetings[11]. Most telling was his statement, "*at that point [Covid-19] is happening elsewhere*".[12] He said the "*signals*" were not there at the time as "*the primary signal*" to start mobilising would be the CMO changing the risk from low to moderate.[13] However, the risk assessment had changed from low to moderate on 30 January 2020, so it is not clear whether he was simply unaware of the change or failed to focus on the risk level to people in Wales. While Mr. Drakeford acknowledged that there was a "*very plausible case*" for saying that the WG should have been making earlier preparations through January and February 2020, he made this acknowledgement only "*with the lens of hindsight applied to it",* stating, *"If we knew then what we know now. There are many things we might have done differently with better knowledge*".[14] The failure to act earlier cannot sensibly be regarded as a matter of *hindsight.*

5. Dr Andrew Goodall was also unclear as to what the risk assessment actually was at the early stage. In his oral evidence, in response to a question as to whether the Health and Social Services Covid-19 Planning and Response Group should have met earlier than 20 February 2020 he said, "*Through February, the overall UK assessment was…was low, it changed to moderate at the end of February.*[15] As stated above, the formal risk level was already moderate by the end of January 2020. Inexplicably, Sir Frank, despite being one of the decision-makers assessing the risk level, failed to accurately state the date it changed in

[5] M2: INQ000203938
[6] M2: INQ000399529/7
[7] INQ000048722
[8] INQ000391237/38
[9] INQ000383585/1
[10] INQ000083240/7
[11] M2B Transcript [11/47/4 - 11/48/13]
[12] M2B Transcript [11/46/21-22]
[13] M2B Transcript [11/49/25 - 11/50/3]
[14] M2B Transcript [11/51/8-10]
[15] M2B Transcript [6/25/14-16]

his witness statement: *"At the end of February, UK CMOs assessed the risk to the UK as moderate noting the criteria that would trigger a re-assessment of the UK response*".[16]

6. The evidence illustrates, and the Inquiry should find, that at the highest levels of WG there was a failure to grapple with and clearly identify the nature and extent of the risk in the early period. As regards the 4 UK CMOs' 30 January 2020 statement of the risk level as moderate (and the Welsh CMO's own statement on 31 January 2020), there was either a significant failure by the WG to communicate that assessment or to take it into account.
7. The minutes of the first Cabinet meeting to consider the threat of the virus, on 25 February 2020, contained the erroneous statement that at that point "*there had been no imported cases into the UK*".[17] Not only was the error in the minutes not spotted and corrected but it was repeated in the witness statements of Mr. Drakeford[18] and Mr. Gething.[19] Further, the minutes do not record a discussion of a plan in response to the virus, merely concluding with "*Ministers would be meeting on a regular basis to consider the implications of the spread of the virus and Cabinet would be provided with a briefing note.*"[20] The Inquiry should find that these matters are telling of the lack of focus at that time on the impending threat. Had there been the intensity of scrutiny and focus proportionate to the threat at that time (when Covid-19 had arrived in the UK) recollections would be clearer, the error in the minutes would have stood out, and witness statements would not have been signed by key decision-makers repeating such an error.
8. The WG should have acted sooner regardless of whether it expected that the Civil Contingencies Act 2004 ('CCA 2004') was going to be used. Even if the UKG would be the ultimate decision-maker on NPIs, it ought to have been appreciated that there would still need to be a response to the pandemic in the devolved areas of health and social care. WG needed to make an informed contribution to any decision-making whichever legal framework was engaged. For example, the WG should have been proactively ensuring IPC measures were in place, hospitals prepared with surge capacity, that care homes knew what to do. They should have started earlier to audit the PPE, liaise with key partners, and establish effective consultative fora in anticipation of the likelihood that the virus would arrive in Wales. The exact types of preventative measures WG could and should have been putting in place are set out in Dr Quentin Sandifer's presentation dated 28 February 2020.[21] Instead, undue weight was attached to the fact that the virus had not yet arrived in Wales, repeated by many WG witnesses, for example, in Mr. Drakeford's witness statement: "*we went through January and February 2020 without seeing any direct impact from the virus. As we entered March 2020 Covid-19 and its seriousness became more apparent.*[22] This ignores the fact that Covid-19 had arrived in the UK by 29 January 2020 and the manner in which it would spread.
9. Public Health Wales (PHW) was mobilising from mid to late January 2020 and by 27 January 2020, assessing and testing suspected cases across Wales.[23] The frustration of PHW witnesses, Dr Quentin Sandifer, Dr Tracey Cooper and Dr Chris Williams, at WG's inaction at the early stage was palpable in

[16] INQ000391115/34
[17] INQ000129852/6
[18] INQ000371209/25 Para 77
[19] INQ000391237/41 Para 164
[20] INQ000022466
[21] INQ000309714/8
[22] INQ000371209/24
[23] INQ000267867/8

their evidence. CBFJ Cymru ask, if PHW could see the pandemic "*coming down the line*",[24] why couldn't the WG? The Inquiry should find that the sentiments expressed by Dr Sandifer are correct and supported by the evidence: ;e stated, "*What I think was missing in the first few weeks from 8 January 2020 when I first became aware to 20 February 2020 when the Health and Social Services Group Coronavirus Planning and Response Group first met, was national strategic leadership and co-ordination from Welsh government*".[25] Mr. Drakeford was dismissive of Dr Sandifer's critique, stating in his oral evidence, "*The fact that he's unable to see something happening does not mean it is not happening*",[26] but, even on Mr. Drakeford's *own* admission, little was being done in that early period. WG witnesses were unable to provide particularisation of actions beyond an "*awareness*"[27] of Covid-19 or "*issuing statements to the Senedd*".[28]

10. Dr Sandifer gave as an example of the deficit in leadership his experience of needing to ask Health Boards to prepare urgently for dealing with cases of Covid-19 in the week of 27 January 2020: he could not tell a Chief Executive of a Health Board or an NHS Trust what to do: WG input with authority to direct was required for that.[29] Rather than attending a cultural event in Brussels on 4 March 2020 Mr. Drakeford would have better served people in Wales by attending COBR and appraising himself of thinking within PHW.
11. As regards the timing of the first National Lockdown, Robert Hoyle, Dr Williams, Dr Cooper, Professor Gravenor, and Dr Sandifer each stated in their evidence their view that the lockdown should have been introduced earlier; the consensus being that up to two weeks earlier would have been preferable. TAG's paper dated 20 July 2020, 'A Calibrated Local Authority Level COVID-19 Epidemic Policy Model for Wales' modelled a lockdown being introduced 5 days earlier, in which it was estimated that 24% deaths in the first wave may have been prevented.[30] Mr. Drakeford in his evidence said that it was only on 21 and 22 March 2020 that a lockdown plan for Wales was being discussed.[31] CBFJ Cymru question why more stringent measures were not being discussed earlier within WG and even if (as has been stated by WG decision-makers) it was unrealistic that Wales would move to a full lockdown before the rest of the UK in the first wave, the WG could have been exerting pressure in COBR for an earlier more stringent response which could have saved more lives.

Asymptomatic Transmission

12. CBFJ Cymru say the possibility of asymptomatic transmission should have been recognised and factored into decision-making at the early stage, rather than, as was the case, ignored because a certain formal level of proof did not yet exist. To do the latter was reckless as to the risk to vulnerable populations of catastrophic consequences. The Inquiry is asked to note Dr Chris Williams' evidence, "*it's always worth considering on the precautionary basis what might be transmission routes*".[32]
13. There was plenty of early evidence that asymptomatic transmission was a possibility. On 20 February 2020, Dr Rob Orford sent an email, '*SAGE: Coronavirus Update 4*' advising, "*From cruise ship – 30-50% asymptomatic-mild*".[33] Further, the SAGE report dated 12 February 2020 stated, "*Asymptomatic*

[24] M2B Transcript [6/147/16-18]
[25] INQ000267867/38
[26] M2B Transcript [11/58/11-13]
[27] M2B Transcript [6/47/8]
[28] M2B Transcript [9/52/4-5]
[29] M2B Transcript [7/32/3-9]
[30] INQ000302585/7
[31] M2B Transcript [11/101/25 - 11/102/8]
[32] M2B Transcript [4/45/9-10]
[33] INQ000384621/1

transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely."[34] At the 21 February 2020 meeting of NERVTAG, "*NF noted that there were a few modelling groups estimating a higher infection rate when comparing case populations in Singapore, South Korea and Japan, this suggests that at least a third have been missed. JE commented on this after the meeting taking into account the issue of asymptomatic cases, where the evidence suggests that 40% of virologically confirmed cases are asymptomatic.*"[35] Dr Williams confirmed in his evidence asymptomatic infections potentially as great as 40% "*would have been part of the thinking by late February*".[36] It is therefore difficult to understand how both Mr. Gething and Mr. Drakeford could continue to deny the significance of the risk of asymptomatic transmission, until later in 2020. This had implications in particular for policy on testing (see below).

Airborne Transmission

14. CBFJ Cymru have emphasised in their statements in M2 and opening statement to this Module the importance of decision-making based on a proper understanding of the mode of transmission of the virus. The scientific knowledge existed from early on that this was an airborne virus. Dr Robert Hoyle, Head of Science in the WG and member of TAG, gave evidence that "*there was a lot of debate about whether it was actually an airborne virus or whether it was passed by touching or fomites […]. [His] view at the time that it was pretty obvious that it was an airborne -- mainly airborne transmissible virus.*"[37] The evidence of Professor Sir Chris Whitty in M2 was that several possible routes of transmission were recognised early on and the general view shifted to suspended aerosol transmission as being of greater importance as was originally thought, leading to a greater emphasis on the role of ventilation.[38] Professor Catherine Noakes in M2 made the important point that people should have been made more aware of the relevant mitigations for aerosol transmission.[39]
15. Against this backdrop, CBFJ Cymru wanted to know if the WG properly investigated all relevant measures to counter aerosol transmission in particular low harm measures including the most effective types of masks, public messaging and actions for better indoor ventilation including in hospitals. For reasons stated further on in this statement the Inquiry should find that WG decision-making on appropriate masks was indeed inadequate. As regards ventilation, whilst it is understood from oral evidence of Dr Cooper of PHW that there was guidance on ventilation, it will be important to examine in the future modules what was the extent of recognition of the need for indoor ventilation and how this was taken forwards in the social care sector and crucially in hospitals.
16. CBFJ Cymru's view is that evidence adduced in this Inquiry to date does not show the WG striving to understand the modes of transmission nor maximise the potential for use of effective low harm interventions to counter aerosol transmission. The group hopes there will be further evidence on this issue in relation to social care and hospitals in the future modules.

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[34] INQ000320718
[35] INQ000119469/6 Para 3.4
[36] M2B Transcript [4/46/19-20]
[37] M2B Transcript [3/185/3-8]
[38] [M2 INQ000248853/100]
[39] M2 Transcript [13/17/10 – 13/18/5]

Mass Gatherings

17. Mr. Drakeford first requested advice on mass gatherings on 9 March 2020[40]. Mr. Drakeford questioned why other countries were banning mass gatherings and sought confirmation as to the scientific basis for not banning them. Advice on the issue ought to have been anticipated and sought earlier. By 11 March 2020, WG received a request from the Welsh Rugby Union for guidance in view of the forthcoming Wales v Scotland rugby match due to take place on 14 March 2020. Dr Orford produced a technical briefing on mass gatherings and behavioural interventions for the First Minister on 11 March 2020[41]. It said, "*Only a modest reduction in the infection related deaths (2%) is predicted for restricting mass gatherings. This is due to the limited exposure time (5.3% of total time), even if the transmission risk is weighted higher. Other measures that impact other more common activities, such as work and home (e.g. self-isolation of symptomatic individuals) have a greater impact on reduction of deaths (11%)*".
18. A Covid-19 Core Group Meeting was convened on 11 March 2020[42]. By this time there were 15 cases in Wales and evidence of community transmission taking place. It was said, "*ministers agreed that there would be a need for further discussions about the policy on mass gatherings, such as sporting and cultural events. The science suggested that such bans would reduce mortality rates by 2%, but there was a need to consider the social impact, the size of events, and whether they were outdoor or enclosed. There were also questions about mass transport hubs. However, it would be difficult to justify not cancelling events, particularly when the Government was advising households to go into quarantine.*"
19. On 12 March 2020 Mr. Drakeford and Mr. Gething attended COBR[43]. The Government Chief Scientific Advisor advised there were an estimated 5,000-10,000 cases in the UK and increasing. The meeting was informed numbers would increase quickly and the UK expected to follow a similar trajectory to Italy. On mass gatherings the minutes note, *"The hardest intervention to call was whether to cancel mass gatherings as the evidence was not there, especially for outdoor events"* and that the "*Scottish Government was minded to advise against gatherings of more than 500 people. Their rationale for this to ensure the frontline emergency workers were able to prioritise the response to COVID-19*".
20. On 13 March 2020 the Football Association of Wales (FAW) cancelled all football until 4 April 2020. On the same day Dr Robin Howe and Dr Cooper of PHW had a conversation with Mr. Gething, expressing significant concern about the Wales v Scotland match going ahead. In his oral evidence, Mr. Gething said on 13 March 2020 active steps were being taken by WG to *"turn off lots of regular NHS activity".*[44] Against this context, WG declined to cancel the Wales v Scotland match, leaving it instead to the Welsh Rugby Union to make the decision whether to do so (which they did). It is clear, and indeed WG accepted in oral evidence, that the Wales v Scotland on 14 March 2020 would foreseeably entail large swathes of people (20,000) travelling to Cardiff and meeting in bars. WG now accepts that it would have been prudent to cancel the match and indeed to advise against mass gatherings generally as this would have given the correct signal to the public. Disappointingly, witnesses made this admission with the strong caveat of hindsight.

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[40] INQ000271446
[41] INQ000271613
[42] INQ000215171
[43] INQ000056221
[44] M2B Transcript [9/102/5-7]

21. From the above chronology it is clear that WG was aware at the time that: i) that other countries were restricting mass gatherings; ii) of rising rates of community transmission; iii) that restricting mass gatherings would result in a 2% reduction in deaths; iv) that the Scottish Government considered restricting mass gatherings would ease pressures on frontline emergency workers; v) that significant concerns in respect of allowing mass gatherings to continue were held by important stakeholders such as PHW and the Welsh Rugby Union; vi) that steps were being taken by others e.g. FAW, to restrict mass events; vii) of the mixed public messaging inherent in not cancelling events whilst advising households to quarantine; viii) that active steps were being taken to introduce restrictions in the NHS.
22. In his evidence, Mr. Gething drew comparison between indoor and outdoor events and the 'cultural significance' of rugby[45] which is quite staggering given the context of risk of loss of human life and in any event does not explain why WG allowed two Stereophonics concerts to proceed on 14 and 15 March 2020. The reality is that notwithstanding what was known by WG at time, it gave no meaningful consideration to restricting mass gatherings. It clung to the line that the science did not support restrictions on mass gatherings, which was misleading. It is also evident that there was unacceptable confusion within WG as to whether it had the power to impose restrictions on mass gatherings. Jeremy Miles gave advice on 13 and 20 March 2020 advising against the use of public health powers to restrict mass gatherings and impose a lockdown. Public health powers were subsequently used by WG, so the initial advice was simply wrong and is indicative of WG's chaotic early response. The above demonstrates total abdication of responsibility by WG and a lack of strategic leadership.

PPE

23. From the very outset of awareness of the threat it must have been obvious that if Covid arrived in Wales, PPE was *bound* to be needed and potentially in large quantities and very quickly. As Mr. Gething's oral evidence confirmed, it turned out WG did not have the stockpiles it thought it had. He confirmed the evidence he gave to the Inquiry in M1, that the PPE stockpile in Wales turned out to be inadequate even for a flu pandemic[46]. In the face of the threat of the arrival in Wales of the novel coronavirus it is difficult to understand why it was not thought that action needed to be taken straightway to check the stockpile and deal with gaps and issues. However, the Inquiry heard that the group tasked with operational co-ordination and oversight for PPE – the Health Countermeasures Group – did not start its work until 12 February 2020, indicating a striking lack of urgency in identifying and thinking through the issues in supply and delivery of PPE. The record of the group's first meeting shows that in effect a "to do" list was compiled of practical actions to be taken to identify what was needed and gaps in the stockpile.[47] It is difficult to understand why this work of overseeing and coordinating preparedness in this crucial area was not started sooner.
24. The evidence showed that help with PPE for the social care sector from WG was slow and at first minimal. The first decision by WG to provide help to this sector was not until 19 March 2020 when a Written Statement was issued by Mr. Gething, stating that, pending arrangements being made for distribution to

[45] Module 2B Transcript [09/107/11]
[46] Module 2 B Transcript [9/41/22 – 43/3]
[47] INQ000298968

local authorities, care providers could approach local health boards for urgent assistance, but these arrangements could only be utilized if a case of Covid-19 had been confirmed.[48]The WLGA "*escalated significant concerns about the limited availability of PPE from the WG stocks for social care staff, including lack of clarity on stock levels and inconsistent and incomplete supplies being made available across authorities,"* and says "*concerns about the supply of PPE dominated early discussions between leaders and Ministers*".[49]

25. The evidence demonstrated that well into April 2020 serious problems with PPE continued, evidenced by the fact that the BMA and Wales TUC felt it necessary to issue a joint statement on 12 April 2020 calling for assurances from the WG that health and social care staff would get the PPE they needed.[50] There is no doubt that those in dire need of PPE in these early weeks were profoundly failed by the WG.

Face Coverings

26. The WG has characterised its actions as being cautious and only diverging from the UKG when doing so was in the best interests of the people of Wales. This narrative is fundamentally undermined by the WG's approach to face coverings. Wales was later than all other nations when it came to advising and/or mandating face coverings. There is now a large body of evidence which demonstrates the effectiveness of face coverings in reducing transmission, though protection is provided not to the wearer but to others.[51] It appears that Sir Frank was a key source of face covering scepticism within WG. This was compounded by failure on the part of ministers – in particular Mr. Drakeford and Mr. Gething – to rigorously interrogate the scientific advice and come to independent conclusions regarding which NPIs were in the best interests of the public. Mr. Drakeford's evidence, that he needed to follow Frank Atherton's advice at all times to avoid undermining his position on other NPIs,[52] reflects a tendency to hide behind the skirts of scientific advice rather than take decisions independently which are nonetheless informed by the scientific advice.
27. On 28 April 2020, the Scottish Government advised the use of cloth face masks in enclosed spaces and on public transport. On 7 May 2020, the Northern Irish executive recommended face coverings in enclosed spaces where social distancing was not possible. Similar advice was given in England on 11 May 2020. It was not until 9 June 2020 that WG recommended face coverings in circumstances where social distancing is not possible.
28. The trigger for WG's change in position on face coverings was WHO advice of 5 June 2020.[53] The "*main change*"[54] in WHO advice was that vulnerable people (defined as over 60s and those with underlying comorbidities) should wear medical-grade face coverings, even in low-risk settings.[55] As a result, WG sought advice from TAG and TAC. TAG convened on 5 June 2020 where face coverings were discussed.[56] England had already announced it would mandate face coverings on public transport from 15 June 2020. TAC generated an advice dated 8 June 2020 at the request of WG.[57] There are two important points to

[48] INQ000252549
[49] INQ000082940/3
[50] INQ000180916
[51] see EMG Consensus statement, SAGE 96, **INQ000311901** INQ000196751
[52] M2B Transcript [11/97/8-19] [11/98/5-10] [11/137/12 - 11/138/15]
[53] INQ000327606/9-24
[54] INQ000274878
[55] INQ000327606/15
[56] INQ000313097 and INQ000313218
[57] **INQ000384971**

note from this advice. The first is the reference to masks carrying the risk of behavioural change. This ties in with Sir Frank's witness statement where he says that one of his concerns was that mask-wearing may promote risky behaviours.[58] This is clearly a question for behavioural scientists, but at this stage, there were no behavioural scientists on TAG or TAC; Professor Ann John who was not approached by Ms Fliss Bennee until 2 June 2020, did not join TAG until 17 June 2020, and the RCBI sub-group did not meet until 22 July 2020.[59] As such, when TAG and TAC were providing advice on face coverings and making assumptions about how face coverings may impact behaviour, they were doing so in an evidential vacuum and failing to highlight their lack of expertise on behavioural science. The risk of face coverings promoting risky behaviours was therefore not based on sound science. While Sir Frank is ultimately responsible for the scientific advice passed to WG, it was incumbent on ministers to challenge this assumption. Ms Rebecca Evans in the WhatsApp messages makes the point that "*[…] one benefit of masks is that they are a visual reminder that coronavirus is still out there, even though we can't see it*".[60] However, this perfectly reasonable challenge does not appear to have been raised with scientists by WG.

29. The second point to take from the 8 June 2020 TAC advice is that it states (p 3):

"• *There would be benefit of recommending, and in certain circumstances providing, medical masks to people who are more likely to have adverse outcomes from contracting COVID-19 (e.g. shielded individuals, BAME, homeless, over 60s).*

• *The effectiveness of medical grade face masks for personal protection is dependent upon wearing them correctly, and effort should be expended to ensure that this is effectively communicated to the public.*

• *It may be necessary for government to take steps to protect supplies of medical grade face masks, to prevent hoarding by individuals who are not in the key at risk groups.*"

30. Also on 8 June 2020, Sir Frank provided advice to Mr. Drakeford which clearly set out the WHO advice on the use of masks for vulnerable groups.[61] A technical briefing of 9 June 2020 again refers to the debate surrounding whether vulnerable people should be advised to wear medical grade face masks.[62] This was discussed in the 9am call on 9 June 2020 ahead of Mr. Gething's 12:30 press conference[63] when it was agreed that WG would recommend rather than mandate face masks at this stage. This decision resulted in further divergence from UKG which had the potential to cause confusion and erode public trust. As Professor Ann John said in her evidence, "*it would have been very confusing to people that […] there was one point where you had to wear a mask on the train till you got to Newport and then you could take it off. Now, there is no doubt in my mind that that […] if we're following the science why are we coming to different conclusions, was difficult for people, and that would have had an impact on trust.*"[64]

31. The second crucial point to derive from this 9am meeting on 9 June 2020 is that at some point between TAC's advice being discussed at the 9am call and Mr. Gething's press statement at 12:30pm all reference to medical-grade face coverings for the vulnerable was removed.[65] The TAC advice published on WG's

[58] INQ000391115/24
[59] INQ000286066/7
[60] INQ000316403/45
[61] INQ000281742/6
[62] INQ000118555
[63] INQ000349582
[64] M2B Transcript [4/119/18-25]
[65] INQ000198395,

website was edited to remove all reference to the need for vulnerable people to wear medical masks.[66] This was put to Toby Mason, whose emails of 9 June 2020[67] reflect an attempt to "bang heads together"[68] to edit the press statement to make it more deliverable from a "comms perspective". However, as the email trail establishes, Mr. Gething had the ultimate sign-off on the press statement. It is of great concern to CBFJ Cymru that Mr. Gething, having full knowledge of the details of the WHO advice, did not seek to ensure vulnerable people in Wales were appraised of it. As a result of the editing down of the TAC advice and Mr. Gething's press statement, the reference to vulnerable people needing medical grade face masks was erased. The only time CBFJ Cymru have been able to identify when any advice was given to the Welsh public regarding vulnerable people requiring medical masks was a written statement on 13 June 2020.[69] This refers to the fact that medical masks have a place for the protection of the vulnerable in higher risk settings only. It sets out that shielded people should wear a medical mask should they have to enter a health or social care facility. The written statement published on 13 June 2020 is therefore targeted at a much narrower group of people in a narrower set of circumstances than the WHO guidance.[70] It is also misleading as it says that there is "*little evidence that the more widespread wearing of medical masks benefits either staff or the public*". This is contrary both to the advice of the WHO and that of the EMG.[71]

32. The second point of divergence was when other nations mandated the wearing of face coverings on public transport. Face coverings became mandatory on public transport from 15 June 2020 in England, 22 June 2020 in Scotland, 10 July 2020 in Northern Ireland. Wales was the latest of the 4 nations and only mandated face coverings on public transport from 27 July 2020. CBFJ Cymru ask the inquiry to note that one of the key reasons given by Sir Frank for not mandating face coverings sooner was due to the potential for risky behaviour. When face coverings were discussed by TAG on 17 July 2020,[72] Professor Ann John was present and there was a significant shift in the discussion surrounding face coverings. It was said, "*Historically, people's behaviours and compliance have tended to fall into line when instructed to comply with new laws and regulations — i.e, smoking in public places to prevent exposure to secondary smoke.*" These sorts of comparisons with other behavioural changes do not appear in the earlier TAG minutes. Further, it is said in the minutes that "*more evidence is needed on whether [Covid-19] is transmitted more by aerosols or by heavy droplets*". The EMG provided an extremely detailed advice regarding aerosol transmission on 22 July 2020 which confirmed that aerosol transmission plays a significant role in transmission of Covid-19.[73] As to the behavioural science aspect of mandating face coverings, it was suggested that the RCBI discuss face coverings at their first meeting on 22 July 2020. On 21 July 2020, there was growing support from TAC and TAG members for the use of facemasks/coverings[74] which was then firmed up in the updated consensus statement on face coverings on 23 July 2020[75] which resulted in the mandating of face coverings on public transport on 27 July 2020. CBFJ Cymru submit that it is significant that the previous aversion to mandating masks appeared to be on

66 INQ000311901
67 INQ000215458
68 INQ000388424/4
69 INQ000421047
70 INQ000281742/6
71 INQ000215630
72 INQ000221034
73 INQ000212029
74 INQ000313117
75 INQ000385402

the basis of behavioural science, on which Sr Frank is not an expert, and when behavioural scientists were present at TAG, expressions of concern about risky behaviours did not materialise. In fact, their involvement in the discussions coincided with a shift in thinking regarding face coverings.

33. As to inside shops, in Scotland and Northern Ireland, face coverings became mandatory on 10 July 2020, and from 24 July 2020 in England. As to other indoor spaces, England extended the list of places where face masks would be mandatory on 24 July 2020. The WG did not impose similar restrictions until 14 September 2020. Therefore, at each stage, Wales was behind the rest of the UK.
34. CBFJ Cymru see no reasonable justification for why WG stuck so steadfastly to this point of divergence on an NPI which was a low risk to the public and had the potential to reduce transmission. Sir Frank in his evidence conceded that for "*all the time and energy that was spent in Wales thinking about face coverings, I do wonder whether it would have been a better decision just to simply align.*"[76] As Professor John states in her witness statement, divergence *"may have quite naturally raised questions about the scientific underpinnings of actions and behaviours being requested of the general public which can cause sustainable behaviours to be undermined*".[77] Sir Frank Atherton did recognise in his evidence that the position was "*confusing*".[78] Therefore, at each stage, WG should have considered whether divergence was likely to undermine public trust in the scientific advice, rather than being led down this path of divergence by the CMO(W), with the justification put forward by Mr. Drakeford being that following his scientific advice was necessary to justify the decisions taken by WG on NPIs.

Testing

35. As with face coverings, testing was an area where WG were consistently behind UKG, and the divergence was not justifiable. On 30 April 2020, UKG expanded the testing regime in England.[79] On 28 April 2020, Mr. Matt Hancock announced an expansion of Rapid Antigen Testing programme which was at that stage only testing critical NHS staff. The programme was expanded to include inter alia, all key workers working in health and social care.[80] The expansion also applied in Scotland and Northern Ireland. However, it was not until 16 May 2020 that the testing regime was expanded in Wales to match that in England.[81]
36. Both Mr. Gething and Mr. Drakeford were asked to account for this by the Senedd. Mr. Gething on 30 April 2020 in front of the Health, Social Care and Sport Committee said: "*but there still isn't an evidence base that widespread testing for every individual, whether asymptomatic or symptomatic, is the right thing to do*" and that he didn't understand the "rationale" for UKG's approach. Again, Mr. Gething in his 2 May 2020 press release stated, "*At present, the evidence does not support blanket testing – it points to testing people who have symptoms and isolating them until the test results come back.*" However, by the end of April 2020, there was ample evidence which substantiated the need for blanket testing. On 8 April 2020, the Covid-19 Core Group discussed the concern about the number of people in care homes that had become infected,[82] and again on 15 April 2020.[83] Mr. Albert Heaney states in his witness statement that on 23 or 24 April 2020 PHE shared the results of a survey of care homes which indicated asymptomatic

[76] M2B Transcript [5/49/24 - 5/50/2]
[77] INQ000286066/30 Para 6.38
[78] M2B Transcript [5/49/14-15] [5/53/8-10]
[79] INQ000182446
[80] INQ000198020
[81] INQ000053221
[82] INQ000311826/3
[83] INQ000311859/1

transmission which was shared with WG. It noted growing international evidence of asymptomatic transmission of Covid-19 in care homes. On 28 April 2020, the Deputy Chief Inspector of CIW advocated for all residents and staff to be tested regularly.[84] On 29 April 2020 an email sent to Mr. Heaney stated, "*DM spoke with VG and FM today about testing etc. They were not convinced that there is scientific merit (nor capacity) to test sector-wide.*"[85] On 30 April 2020, there was a ministerial advice which set out the evidence for testing: "*Whilst it is unclear what role asymptomatic positive individuals play in the transmission of Covid-19 is unknown — some may never develop symptoms, for those that develop symptoms it is generally accepted that individuals may be infectious to others for up to two days prior to onset. There is some evidence to suggest that there are asymptomatic residents who are undetected and be a source of infection.*"[86] Pilot studies are then cited which make clear the role that asymptomatic transmission plays in care homes. While the advice goes on to conclude that testing was not the "*best use of resources*", the evidence regarding asymptomatic transmission is clear.

37. However, in his evidence before the inquiry, Mr. Gething's answer to the question regarding testing was wholly unclear.[87] He at different points suggested that the knowledge was the problem, but also that resources were the problem. Regrettably, CBFJ Cymru consider that the picture is no clearer for Mr. Gething having given evidence.
38. Mr. Drakeford also spoke at a Senedd plenary on 29 April 2020 where he was questioned about the issue of testing. He stated that, "*The reason we don't offer tests to everybody in care homes, symptomatic and asymptomatic, is because the clinical evidence tells us that there is no value in doing so. Because of that, we don't do it. We offer the testing where the advice to us is that it's clinically right to do that.*" Again, this was despite the evidence referred to above. When giving evidence to this Inquiry, Mr. Drakeford was asked about the 2 May 2020 announcement (that there was not the evidence to support blanket testing). His response was "*We followed the advice of the people who were charged with giving that advice and didn't pick and choose between it.*"[88] However, the evidence before the Inquiry is that there was evidence provided to WG by 27 April 2020 which established the need for blanket testing of patients and residents.
39. In fact, Dr Williams had been advocating for a wider testing regime from much earlier. In an email dated 1 April 2020,[89] he advocated for weekly routine testing of social care workers to give "*routine reassurance and also set up a rhythm and acceptance of testing and self-consideration of symptoms.*" When he gave evidence, he confirmed that symptom-based screening alone was insufficient to reduce the risk.[90] Further, it is not clear to CBFJ Cymru whether WG's position on testing changed from one of there being "no value" to being "value" and when the scientific advice in this regard changed, or whether the change was implemented as a result of political pressure.[91]
40. When lateral flow tests became available in autumn 2020, it became easier for more routine screening of health and social care workers to take place. On 16 November UKG introduced routine testing of

[84] INQ000396501
[85] INQ000385276/2
[86] INQ000116607/4 Para 16
[87] M2B Transcript [9/118-126]
[88] M2B Transcript [11/96/16-19]
[89] INQ000228309/2
[90] M2B Transcript [4/54/8]
[91] INQ000093562

healthcare workers in hospitals.[92] Significantly, in Wales however, it was only on 4 December 2020 that WG announced the same. When asked about this, Mr. Gething was unable to give a reason as to why Wales was so much later than UKG in announcing this extension in testing.[93] Moreover, even though such testing was announced at the beginning of December 2020, it is widely reported by the BBC[94] that this was not properly rolled out in practice until mid-March 2021. Further, it was not until February 2021 that the decision was taken to routinely test all social care workers.[95]

Care Homes admissions and testing

41. The WG had to protect hospitals, but this should not have been at the expense of vulnerable care home residents who were in effect locked in, without visitors and without a voice. The WG should have sought to protect vulnerable people in care homes, but the evidence shows WG giving scant attention to their vulnerable position when making its policies. UKG announced its change of policy on 15 April 2020 that all patients discharged from hospital would be tested before going into care homes as a matter of course. The introduction of such testing was later in Wales. Despite the WG policy on 13 March 2020 to create hospital capacity by expedited discharge into care homes, testing for those discharged was not the subject of ministerial advice to Mr. Gething until 30 April 2020 and Mr. Drakeford says it was on 1 May 2020 that he "*decided to approve the testing of patients on discharge from hospital to care homes*".[96]
42. When Mr. Gething was asked about this, his evidence was entirely unclear as to whether the lack of testing of patients being discharged from hospitals was due to a lack of knowledge or resources.[97] Mr. Drakeford, when answering questions from John's Campaign, said it was a fair point that the number of people being discharged per day from hospital without a test was "*not enormous and maybe the amount of testing that would have been needed could have been accommodated*" but "*that's not the advice that ministers had at the time*".[98] The Inquiry is asked to note the clear implication that, at the time, decision-makers, including the First Minister, could not have been engaged in any serious scrutiny of this issue and advice they were given, but passively followed the advice.
43. It is difficult to understand how the policy introduced on 8 April 2020 "*Admission and Care of Residents during Covid-19 incident in a residential setting in Wales*"[99] could have been considered acceptable from any point of view: it directed care homes to accept people being discharged from hospital who had symptoms of Covid-19, It remained in place until the end of that month. This was not a matter of testing or not testing: the 8 April admissions policy stated, "*some of these patients may have Covid 19, whether symptomatic or asymptomatic. All these patients can be safely cared for in a care home if this guidance is followed*". It is easy to deduce that this meant care homes that were clear of Covid-19 could have Covid-19 cases knowingly introduced into them by virtue of this policy. When Sir Frank Atherton was asked about it, he responded "*the numbers were not large*"[100], and that care homes had PPE, when evidence to this Inquiry shows this was simply not consistently the case, a response that was deeply upsetting to those

[92] INQ000227387
[93] M2B Transcript [9/204/25 - 9/205/10]
[94] INQ000420994 and INQ000420993
[95] INQ000145045
[96] INQ000391237/129 INQ000371209/48
[97] M2B Transcript [9/204-205]
[98] M2B Transcript [11/217/2-5]
[99] INQ000389958/22
[100] M2B Transcript [5/71/23]

who lost loved ones in care homes[101]. How this policy came to be made at all, who was consulted and which ministers even noted it, should be subject to further scrutiny in Module 6.

44. The Inquiry should evaluate WG core decision-making in light of the observations and findings of the Older People's Commissioner. The Inquiry heard that in April 2020 the Commissioner asked the WG for an action plan on care homes because "*there needed to be an urgency and focus that I couldn't see at the time*" and a need for "*faster action to protect older people*". The WG's response then was that this would not add value which angered the Commissioner because this was "*at a time when people were dying in care homes and families were distraught*".[102] After the Equality and Human Rights Commission's ('EHRC') involvement the WG agreed to the request at the end of July 2020. The Commissioner and EHRC worked together to scrutinize the WG's record in upholding equality and human rights during the pandemic between April and December 2020 and concluded "*There was insufficient attention given to older people living in care homes and upholding their rights*".[103]

Autumn Firebreak

45. During September and early October, TAG and TAC emphasised that numbers of infections were increasing and local measures may not be effective fast enough to bring the infections down at population level.[104]

46. Mr. Drakeford in his witness statement, suggests that the reason WG could not have commenced the firebreak sooner was because they did not have faith that UKG would agree to fund this[105]. CBFJ Cymru say this is misleading for a number of reasons:

    a. It is clear from the disclosure, that from early October there was an intention for any firebreak to coincide with the October half-term[106] so that there was minimal disruption to schooling. This was also made clear in Professor Gravenor's oral evidence that he was specifically asked to model around the school half-term break[107]. However, this does not address why the first week of the firebreak could not have been the week *before* the half-term break, and the second week of the firebreak during the half-term break, as the impact on schooling would have been the same;

    b. Despite knowing from 21st September 2020 that Wales would need to implement national lockdown measures in order to bring the R rate below 1, WG did not seek modelling advice until 11th October 2020[108], suggesting that the lack of earlier action was not due the financial implications of a firebreak, but prevarication in obtaining the relevant scientific advice and information to enable Cabinet to make a decision. In other words, there was a failure to act with sufficient rapidity proportionate to the risk Wales faced;

    c. There was already furlough funding in place; what WG sought was for the new scheme to be brought forward. However, it is not correct to say that there was no funding in place at all. This point was clearly identified by the Chair;

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[101] M2B Transcript [5/71/23-25 – 5/72/1-3]
[102] [M2B Transcript [2/129/11 – 2/130/5] [2/131/1-5]
[103] INQ000276281/47-50
[104] INQ000313251; SAGE papers 21 September 2020; INQ000066383/2; INQ000228468/2; INQ000228474/2; INQ000066408/2; INQ000374391
[105] INQ000371209/70, para 227
[106] INQ000395839
[107] M2B Transcript [4/192]
[108] INQ000374391

d. Fundamentally, WG imposed the firebreak without the new funding scheme being brought forward by UKG and were able to source additional funding from the funding streams already available to them[109];

e. Finally, WG simply did not ask UKG for funding sufficiently early.

47. Although Mr. Drakeford suggested in his evidence that he had been asking UKG for additional funding since September, in particular, relying upon the COBR minutes of 22nd September 2020, it is clear from those minutes that at all times Mr. Drakeford was talking in general terms about funding for devolved governments to act independently of UKG if the circumstances allowed for it. The first time WG wrote asking for funding for a specific firebreak commencing on 23rd October 2020 was on 16th October 2020[110]. It is submitted that it should have been no surprise to WG that the UKG were not going to bring the scheme forward in time for the firebreak given the lateness of WG's request.

48. WG missed a number of opportunities to approach UKG to ask for the funding they sought prior to 16th October 2020; first, on 5 October 2020 during the CDL call[111]. In an email sent at 10:48 that morning, Ms Bennee suggested that Mr. Drakeford discuss funding of a firebreak with Michael Gove. That call took place at 15:45 that afternoon and Mr. Drakeford again only discussed financial support for the devolved nations in relation to Tier 3 funding and in the most general sense[112]. Documents suggest Mr. Drakeford did not do what Ms Bennee suggested which was to "*ask CDL whether they are willing to provide economic support for a firebreak/circuit breaker around half term.*" It appears from documents there was a further failure to raise the issue of a firebreak at the HMT call on 7 October 2020[113], again at COBR on 12 October 2020[114], and again at a HMT call on 14 October 2020[115], despite having asked for Professor Michael Gravenor's modelling advice by this stage, and the firebreak clearly being within the contemplation of WG as Cabinet determined to implement a firebreak on the very next day. Therefore, according to the documents, contrary to what was suggested by Mr. Drakeford in evidence, the first time UKG received a formalised, particularised request for funding for the specific purpose of a firebreak is on 16 October 2020, only 7 days before the firebreak was due to be implemented.

49. Further, WG suggest that the reason they could not have had a longer firebreak was because of UKG's refusal to provide additional funding. It is submitted that this suggestion must be dismissed because by the time Wales would have been in the third week of the firebreak (i.e. beyond 9 November 2020), the new scheme would have been in force, as it came into force on 1 November 2020. Therefore, lack of funding cannot possibly be the reason why the firebreak was not implemented for longer. The clear advice of CSA for health, Dr Rob Orford, was for a longer firebreak. In emails dated between 14 October 2020 and 15 October 2020, he advised: "*The take home message is that is we act sooner (the end of this week) and for longer (3 weeks, rather than 2) we will have a greater impact in terms of weeks gained (with rate of deaths as a measure of success)*"[116]. This advice was given on the assumption that the firebreak lockdown would be imposed by the end of week commencing 11 October 2020.

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[109] INQ000227915
[110] INQ000216554
[111] INQ000395839
[112] INQ000198969/3
[113] INQ000353150
[114] INQ000083851
[115] INQ000353157
[116] INQ000385731

50. Professor Gravenor's evidence shows that both an earlier and a longer firebreak would have lessened the loss of life in the second wave. He said "*earlier would have helped*"[117] and "I *do think it should have been longer. A longer firebreak could have -- given how effective it was, given how effective it was in reducing Rt a longer firebreak would have set -- if that, if those benefits had continued, it would have set the prevalence down to a very low level, and then we would have headed toward December. I think a four-week firebreak would have put the reset time deep into December*"[118]. He stated that a four-week lockdown would have bought seven to nine weeks,[119] by which time the most vulnerable would have benefited from the vaccine rollout. However, as confirmed by evidence of Professor Ian Diamond, "*During the second wave mortality in Wales was the highest of the four administrations across the UK.*"[120]

51. It appears that a longer firebreak simply did not form part of WG's thinking at the time. Professor Gravenor confirmed that, by the time he was commissioned to provide modelling assistance on 11 October 2020, the thinking within WG was that the firebreak would be for a 2 or 3-week period as he was only commissioned to do those specific models. From Cabinet minutes of 15 October 2020[121], there appears to have been very little debate about the length of the firebreak, despite scientific advice that "a *minimum of a two week lockdown was required but three weeks was preferable"* being made clear to the ministers. That the lockdown would be for 2 weeks and start with half-term appears to have become a *fait accompli* long before Professor Gravenor was asked to model 2 and 3 week lockdowns and Cabinet was asked to make a formal decision.

DNACPR (Do Not Attempt Cardiopulmonary Resuscitation Notices)

52. CBFJ Cymru have significant concerns regarding the use of DNACPR. Many of the Cymru group's loved ones were placed on DNACPRs without due process. On 1 April 2020 the Older People's Commissioner, Ms Helena Herklots, "*issued a public statement and gave a television interview following the shocking letter sent on 27 March 2020 by a surgery to some of its patients saying that they would like to complete a Do Not Attempt CPR form ("a DNACPR form") for them*"[122]. She stated that the letter, sent to patients with serious health conditions, told them they were *"unlikely to be offered hospital admission"* if they became unwell with coronavirus and *"certainly will not be offered a ventilator bed"* and the completion of the DNACPR form *"will mean that in the event of a sudden deterioration in your condition because of a Covid-19 infection or disease progression the emergency services will not be called and resuscitation attempts to restart your heart or breathing will not be attempted"*. It *"listed benefits to the completion of a DNACPR form including that scarce ambulance resources can be targeted to the young and fit who have chance of surviving the infection"*[123]. Ms Herklots described the distress caused by the letter. A joint statement was issued on 6 April 2020 stating, *"age, disability or long term condition alone should never by a sole reason for issuing a DNACPR order against an individual's wishes"*[124]. In oral evidence she stated issues pertaining to DNACPR, together with a "*number of different things happened which, cumulatively, older people who were talking to me or talking to other older people which was being*

[117] M2B Transcript [4/175/6]
[118] M2B Transcript [4/175/12-21]
[119] M2B Transcript [4/193/4]
[120] M2B Transcript [3/80/11-12]
[121] INQ000048796
[122] INQ000181737
[123] INQ000276281/11 para 3.22
[124] INQ000184964/2 and INQ000276281/11 para 3.25

reported to me, there was certainly feeling that -- that sense of, yeah, just not being valued"[125]. CBFJ Cymru anticipate further detailed exploration of the use of DNACPRs in Modules 3 and 6.

Bereavement Support

53. The Impact Films and powerful evidence of the bereaved in M2B served as tangible heart-breaking reminders of loss of life but also the trauma experienced by the bereaved. Against this context, Ms Grant of CBFJ Cymru stated in her evidence '*We have over, I think it's 400 members, and not one person has been offered bereavement support."*[126] When asked about bereavement support, Ms Eluned Morgan[127] said the Mental Health Helpline was available to support during the pandemic. Under scrutiny from the CTI and the Chair, Ms Morgan accepted the Mental Health Helpline provided mental health support as opposed to specific bereavement support and that the bereaved would not necessarily have considered themselves to be suffering from a mental health issue. CBFJ Cymry comment that notwithstanding the inevitable trauma and distress they faced, the bereaved were left unsupported.

Intergovernmental Relations

54. CBFJ Cymru repeat what they said in their Closing Statement in M2 that relations between UKG and the devolved administrations (DAs) during the pandemic should have been conducted in the way that best promoted an effective response to the pandemic across the whole of the UKG; and that this implies striving where possible to reach agreement on common policies and where policy differed, sharing information so that nations could co-ordinate implementation of their respective policies and public announcements: a true Four Nations approach.

55. During the pandemic, things that needed to be in place in order to support a Four Nations approach were not in place. As set out in CBFJ Cymru's Closing Statement in M2, there was a lack of a forum for regular meetings between First Ministers and the Prime Minister. There was a wrong mindset at the top of the UKG, namely that DAs needed to be "managed" rather than worked with. CBFJ Cymru's recommendation in its Closing Statement in M2, is that there must be a formal structure which in a period of prolonged crisis such as a pandemic would provide for regular meetings between Prime Minister and First Ministers. There also needs to be a be an approach on all sides of genuinely attempting to work together to maximize the chances of alignment of policies, where appropriate, and otherwise to share information and co-ordinate actions and messaging.

56. After hearing the evidence in M2B, CBFJ Cymru believe the following further observations are warranted. Although the structures for intergovernmental relations at the First Minister – Prime Minister level were inadequate, there *were* opportunities for regular communication and exchange of information between the WG and UKG. There were for example regular meetings between four UK CMOs and between the four health ministers. It is surprising to read the evidence of Mr. Gething that advice to him on 30 April 2020 about testing on hospital discharge into care homes included the statement "*officials were not provided with full details of UK policy*"[128], and in the record of the discussion that followed, the comment: "*There*

[125] M2B Transcript [2/127 – 128]
[126] M2B Transcript [2/16/7]
[127] M2B Transcript [10/32-33]
[128] INQ000391237/129

was a 4 nations group on testing but Wales did not seem to be fully plugged in"[129]; also in the minutes of the Core Group Meeting on 6 May 2020 there is an entry, "*It had been difficult to obtain clarity from the UKG on its policy for England*" (in relation to policy on testing all residents and staff in care homes where there had been an outbreak)[130]. CBFJ Cymru see no good reason as to why information on UKG policy in key areas could not have been obtained had WG efforts been appropriately focused and directed, and deficits in information about what the UKG was doing on the key issues referred to avoided. The Inquiry should find that the WG did not take a proactive enough approach to these policy areas, and tended to a default position of blaming UKG when WG lagged behind in updating its policies.

57. Although there were circumstances where alignment with UKG would not have been the right option (e.g. deciding not to switch to *Stay Alert* in May 2020 was right), CBFJ Cymru are also of the view that given that the basic science was obviously the same, WG attached too little weight in its decision-making to the advantages in adopting the same policy across the UK, namely strengthening public messaging, enhancing public confidence in measures and avoiding confusion. These factors should have weighed more heavily in the balance in decision-making than was the case. The most obvious example of this was in relation to WG decision-making on face coverings.

58. **Recommendations:** CBFJ Cymru invite consideration of the following:

(i) **Intergovernmental relations**: There should be:

(a) A forum and formal structure for regular meetings between at Prime Minister and First Minister level during a period of prolonged crisis such as a pandemic;

(b) Recognition by all Four Nations of the advantages of an agreed approach across all Four Nations and commitment to striving to reach agreement where possible; where that is not possible, co-ordination of actions and sharing of information about key policy developments as early as possible so that each nation can consider the implications for their territory.

(ii) **Sharing science expertise across Four Nations**: the accessibility for the WG of UK science advice and structures (SAGE and its sub-committees and NERVTAG) should be strengthened by Devolved Administrations being invited from the outset to attend (as participants or, as appropriate, observers) all key groups and committees with full access to all relevant documentation.

(iii) **Public health infrastructure for Wales**: should have the capacity for rapid scaling up of mass testing and widescale test and trace operations.

(iv) **WG's decision-making capability**: WG should review its structures and processes for decision-making, taking into account:

(a) the need to trigger early response from the whole of Government to an emerging threat and for informed leadership by ministers at an early stage (not just its CMO(W) and PHW);

(b) that ministers must exercise scrutiny of advice they receive before making policy decisions rather than passively following the advice they are given(e.g. scrutiny of why scientific advice

[129] INQ000116607/11

[130] INQ000336509/1

they are receiving is different to that given in other UK nations; what policies other UK nations have adopted on the same subject);

(c) the need for effective internal communication within WG of key information (e.g. of the formal risk assessment of UK CMOs; of key observations by SAGE and at COBR about the degree of risk and of how UKG is responding to it);

(d) the need to proactively investigate and make properly informed decisions in a pandemic on *low harm* measures to reduce infection spread (e.g. appropriate mask wearing, indoor ventilation; public messaging).

(v) **Core decisions on infection protection and control - airborne transmission**:

(a) The implications of aerosol transmission of SARS-CoV-2 should be reflected in infection prevention and control measures by greater focus on appropriate mask wearing in healthcare and generally in the community during a pandemic;

(b) Design standards for ventilation in buildings should be enforced;

(c) Attention to public messaging on the need for ventilation to counter airborne transmission.

(vi) **Core decisions on infection prevention and control - asymptomatic transmission**:

(a) Policymakers should proactively ensure that they have the up-to-date information about the modes of transmission of a virus as an essential foundation for their policy-making;

(b) They should take account of the need for a precautionary approach where the science may as yet be uncertain but there is potential for serious harm (such as possibility of asymptomatic transmission impacting on vulnerable residents in a care home).

(vii) **Social Care**: Whilst this area will be examined in a future module, the following relate to core decision-making:

(a) Decision-making on creating hospital capacity must identify and take into account all the implications of such policies for the social care sector;

(b) Decision-makers should pay attention at the earliest stage to the range of ways that infection can be introduced into the highly vulnerable environment of a care home (e.g. staff movement, hospital discharges) and relevant policies for minimising this;

(c) Relevant data on the sector including care homes should be readily available to decision-makers;

(d) Early attention to the needs of those in care homes and those dependant on the social care sector, notwithstanding that care providers may be private enterprises (e.g. support with PPE).

(viii) **Bereavement support services**: should be in place and readily accessible to all who may need them (not just as part of mental health services).

59. **Concluding comment**. CBFJ Cymru are bitterly disappointed that even when giving evidence WG representatives showed little insight into their mistakes and errors and what could and should have been done better relying instead on unjustified references to the benefit of hindsight and a lack of information,

despite clearly displaying a lack of proactivity. There were significant failings in the way WG conducted its core decision-making during the pandemic, and a woeful lack of national strategic leadership. This was to the detriment of people in Wales and especially those who were the most vulnerable to the virus. CBFJ Cymru invites this Inquiry to reflect this in its findings.

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5 April 2024

BEFORE BARONESS HEATHER HALLET

IN THE MATTER OF: THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

CLOSING STATEMENT

ON BEHALF OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU

MODULE 3

INTRODUCTION

1. These submissions are made on behalf of Covid-19 Bereaved Families for Justice Cymru ('CBFJ Cymru'). They supplement the evidence already provided to the Inquiry pursuant to r.9 Inquiry Rules (INQ0000486000; INQ000343992; INQ000486273) and in oral evidence [2/145/11 – 2/177/17]; [39/1/1 – 39/33/9].

2. CBFJ Cymru is a group of bereaved families which came together to campaign for truth, justice, and accountability for all those bereaved by Covid-19 in Wales, following the devastating loss of their loved ones in the most traumatic of circumstances. Since its establishment, CBFJ Cymru has become the most prominent organisation in Wales in the discourse surrounding Covid-19. CBFJ Cymru continues to fight for proper scrutiny decision-making relevant to Wales, particularly that of the Welsh Government.

3. The preparedness of the United Kingdom for a pandemic (the subject matter of Module 1) and political decision-making by the UK Government and Devolved Administrations (the subject matter of Module 2 and its submodules) are key matters of context for the subject matter of Module 3 and these submissions.

4. In its Module 1 Report published July 2024, the Inquiry found (inter alia) that *"the UK was ill prepared for dealing with a catastrophic emergency, let alone the coronavirus (Covid-19) pandemic that actually struck"* and that going in to the pandemic the UK lacked resilience and in particular *"public services, particularly health and social care, were running close to, if not beyond capacity in normal times"*. The Inquiry found that emergency planning structures were "*labyrinthine in their complexity"*, there were *"fatal strategic flaws underpinning the assessment of risks faced by the UK", a "failure to learn sufficient from*

past civil emergency exercises", a *"damaging absence of focus on the measures interventions and infrastructure required in the event of a pandemic – in particular, a system that could be scaled up to test, trace and isolate in the event of a pandemic"* and *"lack of adequate leadership, coordination and oversight"* by Ministers.

5. In respect of Wales specifically, the Inquiry noted that "*For an administration that prided itself on its efficiency of movement because of its relative lack of scale, and which had described itself as operating, effectively, "under one roof", the reality did not match the rhetoric. The system was labyrinthine. The Inquiry was not persuaded by the mitigation offered by Dr Goodall that it made more sense to those within the system than those outside of it. An opportunity to create a coherent and, therefore, dynamic system in Wales had been hampered by undue complexity."*

6. In summary, the Inquiry had "*no hesitation in concluding that the processes, planning and policy of the civil contingency structures within the UK government and devolved administrations and civil services failed their citizens".*

7. The evidence in Module 2 and 2B underscored the passive, slow and disjointed response to the Covid-19 pandemic by the UK Government and Welsh Government. There were clear warnings that from January 2020 what was happening globally could occur in the United Kingdom. In Wales, Sir Frank Atherton had warned the First Minister by 24 January 2020 that "*there was a significant risk the virus would arrive in Wales*" ([M2B] INQ000371209_0023 paragraph 27). The UK Government and Devolved Administrations should have been electrified into action from the end of January / start of February 2020 onwards. It is clear from the evidence the UK Government and Welsh Government failed to grapple with the nature and extent of the risk posed. In particular, the Welsh Government were unacceptably slow to accept and respond to the science, most notably to the possibility of asymptomatic and airborne transmission.

8. Against this context, CBFJ Cymru turns to consider how the healthcare system in Wales fared during the pandemic.

9. On the evidence before the Inquiry in Module 3 (including the evidence of the eight Welsh oral witnesses) there can be no doubt that the Welsh Government and NHS Wales performed poorly.

SUBMISSIONS

10. CBFJ Cymru submits that the following high-level findings are supported by the evidence before the Inquiry in Module 3 and relevant to Wales:
    a. The healthcare response in Wales was ultimately the responsibility of the Welsh Government in the relevant period;
    b. The healthcare response to Covid-19 in Wales was inadequate;
    c. The Welsh Government had sufficient notice, knowledge, and warning of the risks to the lives of people in Wales arising from Covid-19 but failed to take adequate steps to prepare NHS Wales and to support it to respond proactively; and
    d. The Welsh Government has failed to learn lessons.

11. The following submissions are aimed to assist the Inquiry's consideration of its findings: the factual narrative and lessons to be learned in Module 3. The submissions cover:
    a. Accountability in the healthcare system in Wales;
    b. IPC Guidance;
    c. FFP3 Masks;
    d. Testing;
    e. Escalation of Care;
    f. DNACPR;
    g. Access to GP Services;
    h. Shielding;
    i. Compassionate Care and Dignity in Death; and
    j. Recommendations.

ACCOUNTABILITY IN THE HEALTHCARE SYSTEM IN WALES

12. CBFJ Cymru is disappointed that there has yet again been a failure by the Welsh Government to account for what went wrong in Wales. Whether this be the failure to complete comprehensive lookback exercises, a failure to provide key documents to the

inquiry, or the failure of Welsh witnesses to meaningfully reflect or show contrition, there has been a systemic failure in accountability.

13. The Welsh Government and NHS Wales's woeful approach to learning lessons is best demonstrated by its failure to conduct a national lessons learned review. In stark contrast to the approach of other UK Nations, the lookback exercises in Wales have been piecemeal; a patchwork of reviews carried out by different bodies without cohesion or focus; all of them superficial, none of them getting to the heart of what went wrong. Staggeringly, some Welsh witnesses have staunchly stood by the lessons learned work done in Wales. Others, such as Baroness Morgan suggest that the Welsh Government is simply waiting for the Inquiry to report first. While the Inquiry is certainly an important process, it is deeply concerning that the Welsh Government would not want to understand for itself what went wrong in Wales, would not want to armour up as soon possible for the next pandemic.

14. The lax approach to learning lessons in Wales is also illustrated by the, at best, cursory exploration of nosocomial infection. Wales established a National Nosocomial Covid-19 Programme, purportedly to investigate individual patient safety incidents of nosocomial Covid-19. The Welsh Government, through Judith Paget gave no meaningful assurance that all cases of nosocomial deaths had in fact been recorded as patient safety incidents. There has been no national oversight. Further, Eluned Morgan, Judith Paget and her predecessor Andrew Goodall, were somewhat nonchalant as to the absence of a national investigation into cluster outbreaks in Wales. The failure at national level to look at the root causes of clusters outbreaks, represents a clear missed opportunity to identify patterns and potentially life-saving interventions.

15. CBFJ Cymru considers that the inadequacy of the Welsh Government's approach to lessons learned is compounded by its continued failure to open itself up to detailed scrutiny by this Inquiry. CBFJ Cymru has long highlighted concerns that Welsh Government has cherry picked the disclosure it sends to the Inquiry. Separate written submissions dated 29 November 2024 have been made by CBFJ Cymru to the Inquiry in Module 2B which emphasise the nature and extent of the issue. This concern has followed through to Module 3. Vaughan Gething, in his oral evidence, told the inquiry that his discussions with Chief Executives of Health Boards, the CNO, and CMO were minuted, but for reasons that are

not clear to CBFJ Cymru, these minutes have not been disclosed to the Inquiry [35/66/13-23] . This is unacceptable and a complete derogation of transparency.

16. CBFJ Cymru considers that the oral evidence given to in this Module can be characterised by a reluctance in many quarters of Welsh Government and NHS Wales to give open accounts of what went wrong and why, and to accept that mistakes were made – which they undoubtedly were.

17. A feature of this Inquiry has been to highlight that the system in Wales is plagued by blurred lines of accountability which in turn allows for finger pointing instead of answered questions and pro-active action. Notwithstanding that the Welsh Government accepted within its opening statement to the Inquiry that responsibility ultimately rested with them, Welsh Government witnesses have repeatedly deflected responsibility and criticism by deferring to the operational arrangements of the Health Boards who in turn, appear to have been looking to a rudderless Welsh Government for clear guidance and national oversight which did not always materialise.

18. Whilst the Welsh Government and NHS Wales congratulate themselves for things that were done well, CBFJ Cymru says this is because they have not looked closely enough at what went wrong and there remains a wide gulf within which nobody is willing to take responsibility in Wales.

19. Within its oral closing, the Welsh Government has teased a potential acceptance that not all decisions-taken in Wales worked, noting vaguely that issues have emerged or crystallised in respect of NHS capacity; critical care capacity; availability and distribution of PPE; field hospitals; nosocomial transmissions and services available to treat long covid. Frustratingly, the Welsh Government elaborated no further. CBFJ Cymru looks forward to receiving the detail within the Welsh Government's Written Closing.

20. In terms of recommendations, the Welsh Government suggest that "less is more". With respect, given its poor track record for reflection and learning lessons to date, CBFJ Cymru considers that for the Welsh Government "less would in fact just mean less" and there is clearly a need for a suite of substantive recommendations which go beyond the Welsh Government's current proposals if there is to be meaningful change in Wales.

21. With this in mind, we turn to some of the principal issues of concern for CBFJ Cymru.

IPC GUIDANCE

22. First, the Infection Prevention and Control Guidance simply did not address the risk posed by Covid-19; an airborne virus. In particular, from 13 March 2020, the only airborne precautions related to wearing FFP3 masks where AGPs were being conducted (INQ000474282_0060). In the iteration of the guidance dated 6 March 2020 (INQ000339123_0003), it was said that "*Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions*" which was likely to give the misleading impression that the main routes of transmission were the droplet and contact route. In fact, the science was far from clear on that point. In a NERVTAG meeting on 3 February 2020, Professor Van Tam acknowledged that "*we do not understand the relative contribution of fine particles [...]*" and other members agreed that they were making assumptions based on other respiratory pathogens (INQ000119615_0004). Dr Ritchie further confirmed in her evidence that they were basing the response to Covid-19 on its nearest relative, SARS (INQ000421939_0025 paragraph 91). The RPE required when dealing with a number of different pathogens, including SARS, was considered in a paper co-authored by, inter alia, Dr Ritchie and Professor Van-Tam published on 17 September 2013. The mode of transmission is said to be "Droplet/aerosol" with the RPE to be worn is specified as FFP3 respirators ("FFP3s") until the patient is no longer considered infectious (INQ000130561_0005). Accordingly, those responsible for developing the IPC Guidance should have proceeded on the basis of the existing science which was that coronaviruses are airborne and the relative contribution of the different routes is uncertain.

23. In fact, the guidance dated 6 March 2020 goes as far as to say that "*Emerging information from these experiences has highlighted factors that could increase the risk of nosocomial transmission, such as delayed implementation of appropriate infection prevention and control measures combined persistence of coronavirus in the clinical setting*" (INQ000348309_0002) yet staggeringly failed to identify Covid-19 as airborne. This is a position which became entrenched and took a long time to be severed from the IPC Guidance.

24. The iteration of the Guidance dated 18 June 2020 continued to include erroneous statements such as "*Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak. [...] The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. The predominant modes of transmission are assumed to be droplet and contact*" (INQ000300300_0011). Those responsible for drafting the Guidance must have known that this statement was incorrect, firstly, because SARS-CoV was thought to be airborne (see above), and secondly, because, by this stage, the Environmental Modelling Group chaired by Professor Noakes had already reported to SAGE that there was a risk that SARS-CoV-2 was transmitted via aerosols. Indeed, from 5 June 2020, Public Health England stated that all hospital visitors and outpatients should wear face coverings, and all hospital staff should wear surgical masks in all clinical areas by 15 June 2020 "*to prevent the spread of infection from the wearer*" (INQ000474282_0060). Clearly there were people in some quarters who had realised that aerosol transmission was a risk. The only reason why this updated knowledge did not make its way into the IPC Guidance is because people on the IPC Cell, including its chair, Dr Ritchie, did not believe that Covid-19 was transmitted via the airborne route, but via droplet and contact. In fact, Dr Ritchie maintained this stance up and until her evidence in this Module [5/62/1 – 5/186/5).

25. As a result, the Guidance was grounded in the flawed scientific view held by those such as Dr Ritchie that Covid was transmitted via droplet and contact. As a result, insufficient consideration was given to appropriate risk mitigation measures.

26. In particular, there was insufficient consideration given to ventilation beyond the opening of windows. Dr Shin in his oral evidence recommended common-sense alternatives to installing new ventilation, namely UV filtration system and HEPA filters [08/172/3 – 08/174/4] which were low cost and portable. Baroness Morgan flippantly joked that a HEPA filter had been her most disappointing Christmas present [35/195/6-8]. On the contrary, for CBFJ Cymru, HEPA filters are a valuable piece of equipment which could have reduced nosocomial transmission rates and potentially saved lives.

27. In addition to its failings regarding mitigation measures to address aerosol transmission, the Guidance demonstrated an erroneous and dangerous lack of appreciation of the potential for asymptomatic transmission.

28. Dr Warne's evidence was that "*absolutely*", future guidance should assume there to be asymptomatic transmission until the contrary is proven, particularly in light of the evidence of asymptomatic transmission in a range of respiratory viruses, including influenza and RSV [08/23/15 – 08/24/14]. Not only should this have been assumed, but there was some evidence to support this assumption from early on in the pandemic. The evidence from the WhatsApp group from the CMOs demonstrates that, as early as 28 January 2020, Professor Sir Michael McBride had identified that there was evidence "*consistent with asymptomatic transmission during the incubation period*" (INQ000375354_0001). Professor Sir Chris Whitty replied on the same day stating "*Agree. Compatible, probable but not conclusive. […] But we should now assume it may be happening*" (INQ000375354_0002). If that should have been the working assumption, CBFJ Cymru queries why this is not properly reflected within the IPC Guidance. In particular, not enough thought was given to the fact that every patient represented a potential risk, rather than simply those who had tested positive for Covid-19, or who were presenting with symptoms.

29. As to what was meant by "presenting with symptoms", there was too rigid an adherence to the "cardinal symptoms" when there was evidence that, particularly in the case of older people, who didn't always present with fever or chills, cough, and shortness of breath. Instead, they may present with symptoms such as extreme fatigue, headaches, nausea, and/or diarrhoea. Those in charge should have taken greater care to ensure that clinicians understood that Covid-19 did not always present with the three "cardinal symptoms" and to be on guard for other symptoms. The evidence of Miss Marsh-Rees is that in Wales, the three symptoms that were identified on the 111 service were fever or chills, a persistent cough, and shortness of breath and anything outside of those three symptoms that wasn't recognised as a potential symptom of Covid. *Ms Marsh-Rees said "I think many older people don't display those three cardinal symptoms and they, you know, it is extreme fatigue, it's headaches, it's nausea, it's diarrhoea, and some others. We're not suggesting that everybody should have, you know, gone to hospital or needed a test with everything, but the lack of acknowledgement that those were Covid symptoms and, you know -- and it was definitely acknowledged they were by October 2020. It was a real miss"* [39/6/21-

39/7/4]. If Covid-19 positive people did not get tested because they did not present with those symptoms, this presented fertile ground for the incubation and spread of Covid-19 in hospitals. Further, even where there was evidence of Covid-19 symptoms, our members are aware of healthcare workers doing nothing to segregate those individuals or impose further protections until the test confirmed, they were positive.

30. The IPC Cell, though not a decision-making body, became a de facto decision-making body because their recommendations were not challenged. As a consequence, the fundamentally flawed IPC Guidance was simply adopted by decision-makers in Wales without question. In fact, Sir Frank Atherton described the challenge as "*managing the interface*" between the IPC Cell and the rest of the system in Wales [13/41/1-3] which indicates that he saw his role as one of mediating, rather than an acting as an important check and balance to ensure that appropriate IPC Guidance was being implemented in Wales.

31. CBFJ Cymru finds this particularly concerning given that Sir Frank Atherton and the Welsh Nosocomial Transmission Group took a completely different view on the science regarding transmission. For example, in evidence, Sir Frank Atherton suggested that it was understood from a fairly early stage that there was a continuum of droplets to small particles to tiny particles [13/117/4-9]. Despite this, not once did Sir Frank Atherton or the Nosocomial Transmission Group challenge the IPC Guidance or describe it as inadequate. If Sir Frank Atherton did consider that there was at least a risk that Covid-19 was airborne, it is not clear to CBFJ Cymru how he could have considered Guidance which was predicated on the mode of transmission being predominantly contact and droplet, save in the case of AGPs, adequate.

32. Further, Public Health Wales were represented on the IPC Cell and indeed Dr Eleri Davies of Public Health Wales was the Chair from 31 March 2021. We have not heard evidence from Dr Eleri Davies, nor was a rule 9 request sent to her. However, we know that no significant changes were made to the IPC Guidance to address aerosol transmission following her appointment as Chair. This suggests that either Dr Davies agreed with Dr Ritchie's view as to the mode of transmission (apparently contrary to the views of others in Wales), or she understood the part played by aerosol transmission but somehow concluded that the Guidance was sufficient despite the absence of sufficient measures to address the risk.

33. It is unclear to CBFJ Cymru whether the lack of challenge is indicative of the cultural problem in scientific advisory groups in the UK whereby advice becomes mired in groupthink, or whether it was because the wrong people were making the decisions about IPC. Laura Imrie suggested that she did not think that it was the role of IPC guidance to look at ventilation as no member of the group felt that they were qualified to comment on ventilation which suggests a remarkable lack of proper expertise on the IPC Cell.

34. A further key issue with the guidance was the way in which changes were and conversely were not made to it. There were many iterations of the IPC guidance which likely contributed to confusion and non-compliance by healthcare workers. Dr Shin said in evidence that "*If the evidence changes significantly, as we've heard, then it's right and proper to create, to generate and cascade correctly formatted guidance. But there [...] were occasions when new iterations came out it was quite hard to see the differences, and later on in the pandemic it was highlighted which bits changed but sometimes the changes were quite subtle, so it did beg the question sometimes: why is this version needed?*" [8/93/22 – 8/94/7] . While many of the changes were minor and likely of little consequence, there were significant changes which should have been made to reflect the evolving scientific knowledge surrounding aerosol and asymptomatic transmission, however, these were not made in a timely manner or at all. In particular, it took until 1 June 2021 to allow healthcare workers to wear FFP3s if local risk assessments concluded that an unacceptable risk of transmission remained (INQ000474282_0060).

35. Further, there was a lack of openness and honesty about the way in which the changes were communicated, particularly in relation to decisions to downgrade the requirement for all healthcare workers treating Covid-19 patients or suspected Covid-19 patients to wear FFP3s to FRSMs. Professor Gould stressed the importance of transparent communication in this regard; *"[...] it might be very difficult to provide everybody with a high-quality face mask because they might just not be available. So you would downgrade that recommendation, but you would have to say why. [...] So you can upgrade or downgrade your recommendation, but you have to show how you reached that conclusion*" [8/78/6-18]. Dr Barry Jones echoed this sentiment: "*If on March 13 2020 the powers that be that told us it was only droplet and surgical masks were fine and will protect you perfectly well against an airborne thing had actually said "Look, it's tough, there's a world shortage of PPE", we*

would have understood" [4/42/10-15]. Instead, an intellectually dishonest line was taken by those responsible for developing IPC Guidance.

36. As a consequence, there is evidence that healthcare workers did not accept the Guidance intellectually. Professor Gould noted that "*emotionally and intellectually people need to accept that the guideline does genuinely represent best practice*" [8/66/5-7] and that, "*intellectually, people didn't always trust the guidelines*" [8/83/24-25]. This was made particularly stark in the evidence of Ms Nicholls who said, "*It felt like a big echo chamber and what our members were telling us in huge volume is that it didn't feel right on the ground*" [9/80/1-3]. CBFJ Cymru suggests that the reason healthcare workers did not accept the guidance intellectually was because the means of arriving at it was intellectually dishonest and involved those responsible for developing the Guidance holding onto increasingly indefensible decisions in light of the developing scientific picture.

Implementation of IPC Guidance

37. The Welsh Government had long been aware that the NHS estate in Wales was barrier in the implementation of effective IPC measures more generally. These difficulties were brought into sharp focus when the pandemic struck. Notwithstanding this, little was done by NHS Wales to mitigate the concerns relating to the NHS estate to ensure effective implementation of the IPC Guidance, and little was done by the Welsh Government to ensure national oversight on the issue. This represented a missed opportunity.

38. Many of CBFJ Cymru's members witnessed healthcare workers failing to adhere to IPC guidance, most notably failing to wear the correct PPE appropriately or at all. A concerning discrepancy has emerged between healthcare workers and operational leads as to the availability of PPE in the early stages of the pandemic. Policy and operational leads insist that there were no supply issues yet healthcare workers report that they felt unsafe in work due to non-availability of PPE. Where PPE was available, there is no evidence before the Inquiry as to what was being done to mitigate compliance and complacency fatigue and ensure that staff wore PPE correctly. Ultimately, non-compliance with Guidance was not acceptable and placed vulnerable patients at avoidable risk and more should have been to prevent it.

39. CBFJ Cymru is further concerned by the lack of proper segregation of patients in Welsh hospitals. Though there was supposed to be a Traffic Light system in place, those we represent witnessed non-Covid patients placed on Covid wards, Covid patients placed on non-Covid wards, people in corridors, an inconsistent utilisation of those categories. Members intervened to ask for their loved ones not to be placed on a Covid ward, including one family member who was immunosuppressed. They were still placed on a Covid ward, where they contracted Covid and died. Suspected Covid patients were also kept on wards until they tested positive. A total failure of common sense.

40. A Welsh Government report disclosed to the Inquiry states that "*Nosocomial transmission of COVID-19 is unfortunately widespread in health boards/ Velindre Trust across Wales. Hospital transmission of COVID-19 has been a major safety and quality concern for all NHS organisations since the start of the pandemic. Actions to address this need to take account of the multiple factors that influence hospital transmission and the particular nature of the virus itself. In the week ending 14/2/21, a Wales total of 211 hospital onset cases (definite or probable) were reported. This represents 8% of all confirmed COVID-19 cases and 53% of total COVID cases within Welsh hospitals*" (INQ000227307_0001).

41. What is particularly mystifying for those we represent is that nosocomial transmission was worse in the second waves (INQ000227307_0001), despite there being a period in the Summer of 2020 where lessons should have been learned from the first wave. Instead, no lessons were learned. The rates of nosocomial transmission in hospitals increased and more people died as a result.

42. The evidence betrays a belief that nosocomial transmission was an inevitability. There were a number of witnesses who were reluctant to accept that the point of IPC is to reduce nosocomial transmission. Sir Frank Atherton, when asked whether the issues with frequent or repeated hospital outbreaks was an indication that the IPC measures were either not effective or not being implemented, said "*In hospital settings it's impossible to completely eradicate nosocomial transmission. […] You will never eradicate it but you should reduce it as much as you possibly can*" [13/52/5-18]. The problem with this position is that there does not appear to ever have been a decision taken by the Welsh Government or anyone responsible for the NHS in Wales for what an "acceptable" level of nosocomial transmission might be. Therefore, there is no benchmark against which to measure what

amount of nosocomial transmission is inevitable, and what is avoidable. This fatalistic approach is made clear in the NTG internal audit service report dated 1 September 2021, where it is said "*The NTG ... routinely monitors rates of transmission, as discussed below, but not with the expectation there is a direct correlation between the guidance issued and lower infection rates*" (INO000022598_0003). When asked about this, Sir Frank Atherton said, "*you'll have to ask the internal audit people*" [13/64/15-16]. This evidence underlined the concern of CBFJ Cymru that the Guidance was merely a sticking plaster covering a festering wound.

FFP3 MASKS

43. If the IPC Cell were proceeding on the basis that the measures should reflect that which would be in place for SARS-CoV, then FFP3s should have been recommended for healthcare workers treating Covid-19 patients and suspected Covid-19 patients. This was the recommendation from the 2013 paper co-authored by Dr Ritchie, in which it was noted: that "*Surgical face masks provide a barrier to splashes and droplets impacting on the wearer's nose, mouth and respiratory tract. They do not provide protection against airborne (aerosol) particles and are not classed as RPE*" whereas "*A respirator is used by an individual to provide respiratory protection. [...] Although most of the evidence base supporting the use of FFP respirators in the prevention of airborne transmission of infection is based upon N95/FFP2 devices, FFP3 is the only FFP class acceptable to HSE for use against infectious aerosols in health care in the UK (Appendix 3). In the USA, N95 (approximately equivalent to FFP2) is acceptable, as is the case in a number of other countries*" (INQ000119615_0003).

44. However, the reason why there was a downgrading of the recommendation remains unclear. If the reason was lack of availability, decision-makers should have been honest about this. Instead, the witnesses have sought to suggest that there is in fact a lack of evidence to support the recommendation to wear FFP3s. Both Professor Susan Hopkins and Professor Chris Whitty gave evidence which was dismissive of the evidence which suggests that FFP3s afford a greater degree of protection. Their rationale was that the evidence demonstrating that FFP3s afford a greater degree of protection is confined to laboratory studies, the implication being that these studies are not reliable. However, there are numerous reasons why that which was established in a laboratory setting may not have been

reflected in clinical studies; the clinical studies may not appreciate that healthcare workers are wearing the masks incorrectly or inconsistently, and they may not reflect the fact that healthcare workers take off their masks in break areas. The lack of evidence from clinical studies does not undermine the clear evidence that FFP3s provide more protection if fit-tested and worn properly. As to this issue, CBFJ Cymru relies upon paragraph 187 of Professor Beggs's report (INQ000474276_0074).

45. CBFJ Cymru submits that decision-makers became too tied to the need for a high level of evidence to prove that FFP3s were more effective. What was needed was a common sense approach. When people's lives are at risk, it is better to be safe than sorry. Further, there was too much focus on FFP3 or FRSM. Where it was not realistic to provide FFP3s in all circumstances, consideration should have been given to recommending FFP2s as an alternative to FRSMs. The extent to which the availability (or otherwise) of FFP3s was driving policy decisions remains a real concern to CBFJ Cymru, especially in light of the minutes of the IPC Cell discussion on 22 December 2020 where one member said: "*If we increase the use of FFP3 masks we need to consider stock availability, as this could put additional pressure on Trusts*" and another member said "*Our understanding of aerosol transmission has changed. A precautionary approach to move to FFP3 masks whilst we are awaiting evidence should be advised*" (INQ000398244_0003), however, this does not appear to have been the consensus view as no such recommendation was ever made.

46. As to the stance that FFP3s should only be worn when AGPs were taking place, this strict dichotomy in the Guidance between AGPs and any other activity further undermined the rationale for the Guidance when it would have been instinctively clear to healthcare workers on the ground that no such strict dichotomy exists. This was confirmed by Dr Warne's evidence that simply coughing generates aerosols [08/51/2-24]. This stance is further undermined by the study conducted by HSJ Intelligence which demonstrates that anaesthetists and intensive care doctors who were working in AGP hotspots while wearing FFP3 masks were at less risk than staff working on general wards (INQ000352887_0008). It is posited in an article published in Clinical Medicine (INQ000352883) that a reason why those thought to be at the highest risk of infection but who did not demonstrate higher levels of mortality was that they were wearing proper RPE.

47. The IPC experts recommended that, in future, where there is a suspected or confirmed respiratory virus, the guidance should include routine use of FFP3 [8/41-44]. CBFJ Cymru adopts this recommendation.

TESTING

48. A key measure for reducing nosocomial infection is the routine testing of asymptomatic healthcare workers and patients.

49. We have heard from many witnesses, including Dame Ruth May, that testing played a vital role in reducing nosocomial transmission. Dame May spoke in her evidence about the importance of staff testing and recommended greater consideration of *testing because not only would visitors have been back earlier, staff would have been safer but patients would have been safer too* [6/89/17-20]. The importance of testing was also acknowledged by the Chief Nursing Officer for Wales, Jean White who stated when asked about the importance of testing:

Absolutely. If you want to try to enable the system to keep delivering other care, you need to separate out those folk who have got an infectious disease from those folk who don't, so that you're able to have, I hate to say, sort of a clean system, but those not affected. I don't know what language I should use here which doesn't sound inappropriate, but you understand what I'm trying to say [6/122/5-12].

Testing of Healthcare Workers

50. Despite this, Wales was later than England in introducing PCR testing of asymptomatic healthcare workers and were also later in introducing routine testing of healthcare staff when Lateral Flow Tests became available. Routine testing of all healthcare staff was introduced on 16 November 2020 in England. It was not until 4 December 2020 that the Welsh Government's policy requiring routine testing of all healthcare workers was announced with implementation following much later.

51. The evidence before this Inquiry is that the Welsh Government knew about the importance of regular testing as early as May 2020. On 4 May 2020 there was a senior clinicians group

meeting, of which, Sir Frank Atherton was a member. It was emphasised at that meeting "*Need to be really clear why we will not test all HCWs*" (INQ000398255_0008). Further, notes of a meeting attended by Sir Atherton with the Royal College of Surgeons suggests that Sir Atherton recognised "*that facilities can't be kept completely covid-free but keeping them covid-light comes back to testing and how testing is used.*" Sir Atherton also recognised in that same call that there was a need for "*updated guidance and significantly data on risk, especially hospital transmission rates…*". To epitomise the woeful system in Wales, the Royal College of Surgeons expressed in response to its meeting with Sir Atherton that "*astonishingly if someone tests positive for Covid-19 it doesn't automatically go into their patient records. They are responsible for telling their GP etc if they have tested positive (0 Jesus wept...)*" (INQ000409291_0001).

52. Prior to the Inquiry, the Welsh Government has long provided different excuses for the delay in introducing routine testing of staff. When asked about the delay by BBC Wales Live in November 2021, Chris Jones the DCMO seemingly downplayed the importance of routine testing[1]. It is understood that Eluned Morgan had earlier told Radio Wales Drive that the delay was occasioned by the need for a strategy[2]. CBFJ Cymru considers both responses entirely unsatisfactory and hoped that greater clarity would be forthcoming within this Inquiry. Unfortunately, this has not come to pass.

53. When asked for clarity as to the reasons for the delay in this Inquiry, the Welsh Government has continued to provide a range of unsatisfactory and confused excuses. Sir Frank Atherton took little responsibility and instead blamed the UK Government, suggesting that policy leads at UK level didn't communicate rapidly with their counterparts in Wales, stating:

Testing was a bit of an issue, the testing strategies generally, I mean. Although information on the public health basis flowed very smoothly, I think, between the Chief Medical Officers, sometimes – because the work -- understandably, because the work was being undertaken so rapidly, sometimes policy leads at UK level, in England, let's say, didn't communicate as rapidly as I would have liked with colleagues who were working on similar issues in Wales and that did lead, I think, to some divergence and some difficulties in keeping up with everybody was doing. [13/26/3-13].

[1] https://www.bbc.co.uk/news/uk-wales-politics-59247429
[2] ibid

54. A different excuse was suggested by Andrew Goodall [31/ 56/1-17] and Vaughan Gething [35/112/22 – 35/113/14] grounded in the absence of LAMP technology in Wales, but this does not explain the delay in implementing regular testing with lateral flow devices which were available to all four nations from the same date.

55. A further view was offered by Dr Susan Hopkins who suggested in her evidence to the inquiry that "*Wales made the decision that regular testing of healthcare workers was something where they thought there were other interventions they wished to do before this* notwithstanding that Wales *agreed with the early evidence that it was providing an effective route to reduce transmission from HCW to HCW*" [7/220/6-11].

56. The reason for the delay in the introduction of routine testing of all healthcare workers in Wales therefore remains unclear and is inexcusable.

57. To compound the delays, despite the Welsh Government's announcement in December 2020, the roll-out of routine testing of **all** healthcare workers Wales did not in fact commence until January 2021 and was not implemented on the ground until as late as August 2021 in some cases as per the evidence of Professor Kloer [30/162/12 – 30/164/18].

58. When asked whether the delay in implementation exposed patients to the risk of infection from healthcare workers, Dr Warne, Professor Gould, Dr Shin opined that this would have "*increased the risk of transmission from healthcare workers – asymptomatic healthcare workers to patients*" [8/184/14-16].

59. Against this context, CBFJ Cymru has endeavoured to understand why there was a delay in implementation.

60. Professor Kloer's written evidence (INQ000475209_0016) describes operational difficulties surrounding implementation of the Welsh Government's policy as follows:

At the time of this announcement there were no secure supply lines, or reporting system, in place for the delivery and processing of LFDs. There were also concerns about LFD's

sensitivity and specificity. The second wave of Covid was rapidly accelerating and staffing issues were to the fore. Accordingly, the HB's Executive Team took a considered decision not to introduce immediate general staff screening, which have would have involved around 9,000 HB staff plus primary workers, but a phased approach whilst the reporting system for LFDs was fully digitalised. There was an added concern that the manual inputting of data, then necessary for LFD processing, would divert resources from the vaccination programme, then a HB priority, and any false positives generated by the testing programme, an unknown, would further stress an already depleted workforce.

61. These operational difficulties ought to have been known to the Welsh Government through stakeholder engagement and strategic plans implemented in advance of the announcement to assist NHS Wales in the delivery of Welsh Government policy. On the contrary, it is deeply concerning that senior witnesses such as Vaughan Gething did not appear to be aware of the delay in rolling out routine testing until evidence heard in this Inquiry. When asked if he accepted that the delay in the introduction of routine testing was unacceptable, Vaughan Gething stated "*Yes, that -- I was surprised by that evidence, because I would have expected for something like that that I'd have been made aware and that Welsh Government officials would have been aware as well about the fact that there was a different choice being made. As far as I recall, nobody came to me and said, "This isn't happening and nothing is being done about it". So I was surprised at that part of the evidence from Dr Kloer"* [35/113/22-35/114/5]. This begs the question as to why Welsh Government wasn't taking proactive steps to monitor the rollout of the testing programme and ensuring that Welsh Government policy was being implemented.

62. Another example of Welsh Government's chaotic and 'hands off' approach to testing can be found in the evidence of Professor Jean White. Professor White was not only Wales's Chief Nursing Officer but also Co-Chair of the Nosocomial Transmission Group. Notwithstanding these important roles, Professor White stated that she "*played no role"* in ensuring the testing of nursing and midwifery staff [INQ000480133/0100]. CBFJ Cymru struggle to understand why this would not be her responsibility. Whose responsibility should it have been? The answer to that remains unclear. Professor White also displayed a worrying ignorance of the scientific understanding of the virus and the difficulties in the implementation of routine testing of healthcare staff in Wales. When asked to account for the delay in introduction of routine testing of healthcare staff until 2021, Professor White

stated, *"I think the issue is more around asymptomatic testing because at the early days we didn't know that the disease could be spread by those who weren't showing any symptoms and therefore you didn't know that they had it in order to spread it"* [6/123/8-12], notwithstanding that asymptomatic transmission was clearly recognised as early as January 2020 (see paragraph 28 above).

Patient Testing

63. Wales was also later than other UK nations in introducing regular testing for patients.

64. The Welsh Government's main guidance in respect of patient testing was given in March 2020 (INQ000048570), June 2020 (INQ000299363), July 2020 (INQ000275673) and January 2021 (INQ000227387) but a Patient Testing Framework was not issued until March 2021 (INQ000081893).

65. The initial guidance in March 2020 only recommended testing of patients requiring overnight admission if symptomatic (INQ000048570).

66. On 3 June 2020 the 'A principles framework to assist the NHS in Wales to return urgent and planned services in hospital settings' (INQ000299363) guidance was introduced which recommended testing as follows:
    a. *Emergency Admissions: all patients should be tested on admission. For patients who test negative, further testing should be undertaken if COVID-19 symptoms are present / develop.*
    b. *Elective Admissions (including day surgery): Plans should be developed for patient self-isolation and pre-admission testing Patients (conducted a maximum of 72 hours in advance) taking into account the type of procedure / treatment to be undertaken.*
    c. *Inpatients: any inpatient who becomes symptomatic, who has not previously tested positive, should be immediately tested as per current practice*
    d. *Outpatients / diagnostic interventions: testing and isolation to be determined locally, based on patient and procedural risk.*
    e. *Discharge: all patients being discharged to a care home or a hospice should be tested prior to discharge.*

67. Notwithstanding the guidance, it does not appear that sufficient testing was occurring in NHS Wales. On 9 June 2020, Andrew Goodall observed in an Executive Call that *"looking at testing numbers - not doing a lot of testing in NHS environment! Not testing in hospitals"* (INQ000300091_0036). It is unclear what was done, if anything, to address this concern.

68. The recommendation that all patients should be tested on admission was not enshrined in Welsh Government policy until 15 July 2020 (INQ000275673) at which time the testing strategy mandated testing as follows:

- *Emergency Admissions: all patients will be tested on admission. For patients who test negative, further testing will be undertaken if COVID-19 symptoms are present or develop.*
- *Elective Admissions: when prevalence in the community is high there is merit in providing testing for elective admissions (including day surgery), where patients will be required to self-isolate and pre-admission testing undertaken (conducted a maximum of 72 hours in advance), this will take into account the type of procedure or treatment to be undertaken.*
- *Outpatients / diagnostic interventions: utilise testing and isolation which will be determined, based on patient and procedural risk. When using the test to inform discharge for individuals whose symptoms of COVID-19 have improved, then a negative RT_PCR, taken 14 days after onset and/ or a detectable antibody level is consistent with an absence of infectivity.*
- *Discharge: all patients being discharged to a care home or a hospice will continue to be tested prior to discharge to ensure that they do not transmit the virus into closed settings.*

69. When asked about the delay in the mandating of testing of all emergency admissions until July 2020, Professor White stated *"I think we gave them a run-in time to actually get the systems in place in order to do that consistently. Now, obviously, once the guidance is out there, there will be early adopters but some folk will take a little bit longer to get systems in place. So often we would give them a couple of weeks' time lag to get to a position where everybody was doing it. It's a big system"* [6/121/14-21]. These operational difficulties ought to have been known to the Welsh Government through stakeholder engagement and strategic plans implemented in advance of the announcement to assist NHS Wales in the delivery of

Welsh Government policy. The Welsh Government's approach screams 'laissez faire' at a time when clear direction was required.

70. Finally, it was only in the January 2021 guidance that the Welsh Government first recommended testing of **all** patients on admission (with further testing of asymptomatic in-patients at day 5). The Patient Testing Framework to support the strategy did not follow until 9 March 2021 and it was only in that framework that the Welsh Government recommended a regime of re-testing at 5 day intervals and, in areas with high rates of nosocomial transmission an additional regimen of retesting at 3 and 7 days may be adopted (INQ000081893_0006). No explanation has been given by Welsh Government for this delay. CBFJ Cymru consider this once again to be an example where Wales was painfully slow in circumstances where speed and agility was required.

ESCALATION OF CARE

71. A further area of concern for CBFJ Cymru relates to escalation of care.

72. The powerful impact evidence of Paul Jones, and the distress he and his wife Karen suffered when their daughter Lauren was not escalated until her oxygen levels became dangerously low [INQ000486000/0007] will, no doubt still be with the Inquiry. Anna-Louise Marsh-Rees explained that when her father's oxygen levels dropped dramatically, the hospital could not find a high-flow oxygen machine to support him for 40 minutes by which time she was told "that ship has sailed" [39/14/16-17].

73. It is trite that there had been a long-standing issue in respect of critical care capacity in Wales. A Welsh Government Task and Finish Group on Critical Care report dated July 2019 (INQ000466422) shows that since at least 2014 Wales's Critical Network's critical care capacity was 5.7 beds per 100,000 of the population (compared to 7 in the rest of the UK and the 11.5 average across Europe) and that an additional 73 critical care beds would be required across Wales immediately. Notwithstanding the alarming results of the 2014 study, the 2019 Task and Finish Group reported *little recent change* in the number of beds available for critically ill patients across Wales.

74. Further, Dr Daniele Bryden gave evidence that the intensive care bed-fill rate in Wales was estimated to be at least 95% in 2018 (10% above that recommended for safe and efficient patient care). When asked what impact this would have had when the pandemic struck, Dr Bryden stated: "*So we have a situation where you have inadequate numbers of staff who are able to respond, and you also don't have the facility, the estate in order to take increased numbers of patients, and it does impact in terms of the ability to manage patients within the footprint of an intensive care service. So we know that when there's a high bed occupancy it does impact on how we deliver care to patients.*" [INQ000389244/0023] [17/175/12-17/176/12]

75. Put simply, it is undeniable that Wales's critical care capacity was objectively lacking in resilience at the outset of the pandemic and further, that little was being done to rectify the situation.

76. The Welsh Government and key Welsh witnesses have been at pains to stress that critical care capacity was not breached in Wales, however, the accounts given by the bereaved and those working on the frontline in Wales point toward healthcare workers feeling pressured to make decisions about escalation and access to critical care, patients being turned away from critical care who would otherwise have been admitted to critical care, and gatekeeping access to treatment.

77. Within its oral opening statement, the Welsh Government stated, "*As far as the Government is aware, there were no incidents where a patient who was clinically appropriate to receive critical care was unable to access a critical care bed in the in the relevant health board area or at least from a neighbouring health board area.*" Further, Andrew Goodall asserted in his statement that Wales had beds free through the first and second wave [INQ000485721_0163 paragraph 416) , and that whilst there was some capacity issues in health boards for short periods, he was not aware of any patient who was deemed would clinically benefit from critical care not getting access to a critical care bed or a bed providing enhanced support (INQ000485721_0216 paragraph 537). CBFJ Cymru submits that the Welsh Government's ignorant optimism is misplaced. In his oral evidence, Vaughan Gething accepted that "*The global figure not being breached showed that we had more capacity to surge into*" but it did not mean that all patients got the treatment they required at the time they needed it; *"Whether people got the appropriate treatment is*

actually a matter about what was taking place with and for that person. And even in a time where capacity is not breached it's possible for people not to get the care that they need." He further conceded that, though it was never brought to his attention that people were not getting the critical care they needed "*That doesn't mean it didn't happen"* [35/112/10-11].

78. Vaughan Gething's concession is the only common-sense conclusion to draw from looking at the critical care data available to decision-makers in Wales, which only demonstrated the global figure for critical care beds. Andrew Goodall was questioned at length regarding the adequacy of Welsh data. Put bluntly, CBFJ Cymru considers that the data being used by the Welsh Government was completely deficient for the purpose of any meaningful analysis and informed response. For example, it does not appear that the data differentiated between beds that were theoretical and beds that were functional and ready for use. Asked about the level of granularity of the data available to Welsh Government, Andrew Goodall asserted that the Welsh Government *"would have expected the health boards"* to have data showing which beds are ready to be used, which beds are in surge capacity, which beds are purely theoretical, how many patients are receiving CPAP, how many additional beds are available for patients who need mechanical ventilation etc [31/9/18 – 31/10/11]. This was important data that should have been collated, analysed and held by Welsh Government

79. It is particularly telling that the Chief Information Officer from Cwm Taf Morgannwg ([M2B] INQ000409575_0019) has been critical of the limitations on the data collected by Welsh Government stating: "*The recording of CPAP use was never resolved in Wales. As a result the sitrep reports were never relied upon by anybody undertaking analysis. Rather than addressing the shortcomings, the publishers presented the numbers with a warning on that they included suspected numbers ... The absence of reliable CPAP data meant that we went through the first and second waves unable to evidence our preparations as to whether we had enough CPAP machines and oxygen to meet need ... The lack of data diminished the ability of clinicians to use data to audit and compare the effectiveness of care for Covid patients. Better data would potentially have helped care optimisation or have helped the clinical teams to make changes to how they delivered care earlier."* This account is a damning indictment on how the Welsh Government's poor data collation and analysis impacted on the delivery of care to patients in Wales.

80. The height of the Welsh Government's position, therefore, must be that there was always theoretically a critical care bed available somewhere in Wales during the pandemic. The data does not demonstrate that individual hospitals did not breach capacity, that these critical care beds had available to them the appropriate staffing levels, that the bed was in the right place at the right time, nor does it demonstrate that the bed came with the requisite equipment such as a ventilator. Accordingly, the Welsh Government's statement that as far as they are aware it never breached capacity does not in any way demonstrate that people in Wales received appropriate escalation of care in all circumstances.

81. The Inquiry heard important evidence from Professor Summers and Dr Suntharalingham who opined that variations in decision making and conscious or subconscious application of clinical thresholds are likely to have occurred, and that ICU admission changed via local informal processes meaning those who might ordinarily be admitted to Intensive Care Units were not. They also highlighted that care delivered on the ward was not captured in measures of ICU admissions collated by ICNARC and accordingly the data underestimates number of critically ill patients (INQ000474255_0061) [15/40/19 – 15/41/2]. Further, the evidence of Kathryn Rowan of ICNARC highlighted that from the data "*there is evidence that there were some changes in the characteristics, management and outcome of patients admitted to critical care during the peaks of the pandemic waves when capacity strain was at its greatest*" (INQ000480139_0010 paragraph 7.6). Further, IFF Research (INQ000499523) suggests that of all healthcare professionals ('HCPs') surveyed, over half reported that some patients could not be escalated to the next level of care due to lack of resources and significantly, 1 in 3 HCPs reported that they received instructions from their employer on which groups should not be escalated to the next level of care. Most HCP's reported having to act in ways which conflicted with their values.

82. The patterns observed across the UK were also observed in Wales. The witness statement prepared on behalf of Cardiff and Vale University Health Board (INQ000480136_0024 paragraph 81), noted that very few patients were transferred to other Critical Care Units. The statement notes that unlike in England, Wales's Critical Care Network is not an operational network and although capacity was continually measured and daily conference call meetings took place, formal capacity balancing agreements were less rigid in Wales. The statement notes that at UHW, over capacity events were primarily managed with dilution of nursing ratios rather than patient transfers.

83. This statistical analysis is supported by the anecdotal evidence, not only of the bereaved, but of critical care doctors themselves, one of whom who said: "*We knew it wouldn't help because we had come to see what kind of people died of this disease despite escalated care. So we decided not to admit to critical care whereas had they had a different illness, they probably would have been more likely to benefit so we would have escalated. We didn't have enough space to give people a go who had a very remote chance of getting better. If we had had more capacity, we might have been in a position to try*." (INQ000499523_0022)

84. This evidence plays on the minds of CBFJ Cymru, many of whom had loved ones who died outside of the intensive care unit or respiratory wards. The torturous thought of what might have happened if only their loved one had been ventilated sooner or at all, and the wondering of whether their loved ones would have been able to celebrate this Christmas with them, if only they had had access to care they would otherwise have received in peace time.

85. CBFJ Cymru submit that informal variations in ICU admissions, combined with the data underestimating the overall number of critically ill patients, perpetuated the Welsh Government's myth that critical care was not saturated.

86. Another reason why the admission numbers to critical care units must be treated with caution, is that in Wales, as in other nations, staffing ratios were diluted to avoid breaching capacity and critical care was provided outside of ICU. Professor Summers gave evidence as to the importance of care being delivered on a critical care unit due to staffing ratios and the experience of care providers [19102/3-18]. CBFJ Cymru considers that those patients in Wales who were critically ill but managed out of critical care were put at risk. The risks posed to patients as a result of diluting the staff to patient ratios was acknowledged by Professor Jean White in her oral evidence [6/105/21 – 6/10] which reflects the contemporaneous view expressed to her in an email dated 12 January 2021 where it is stated "*Sorry for the delay in replying on Monday for example, 11 of the 13 ICU units were on a 'stretched nursing ratios 1:2 for level 3 patients'. Redeployed staff have been moved to critical care to help out these units. However, given the whole hospital strain and vast number of patients in critical care, redeployment hasn't actually been 100% enough for all*

critical care patients / units in Wales. Uncertainty around the impact of this on the quality of care and ultimately to the outcomes of the patients." (INQ000412539_0003)

87. Rather than congratulate itself for never breaching critical care capacity, CBFJ Cymru asks the Welsh Government to look behind the data toward the material reality of what hospital looked like for those patients who desperately needed care. The data does not tell the whole story. It does not show the conscious and subconscious decisions made by doctors, the diluted nursing ratios, whether there was sufficient capacity for ventilators, medication, equipment and consumables in the hospital where it was needed at the time it was needed.

88. As Professor Summers and Suntharalingam stated in their evidence, it is the role of national bodies to step into that breach and support not only their members but the wider patients and public in order to provide variation and provide consistency among the four nations, but also to make sure the staff do not have that moral injury of feeling themselves in that position without external support of people that are meant to be representing and protecting them. [19/96/24 – 19/97/7].

DNACPR

89. The evidence heard in Module 3 has highlighted that at the outset of the pandemic unacceptable practices surrounding DNACPR and use of the CFS (and other crude scoring matrices) in the escalation of care were widely reported.

90. On 27 March 2020 a General Practitioner Surgery in Maesteg sent letters to those with life threatening illnesses asking them to complete a DNACPR (INQ000400633). The letter states that they would "*unlikely to be offered hospital admission*" and *"certainly will not be offered a ventilator bed"* if they became unwell with Covid-19. The letter identifies several *"benefits"* to completing a DNACPR including *"1/your GP and more importantly your friends and family will know not to call 999. 2/ scarce ambulance resources can be targeted to the young and fit who have a greater chance"*. The letter states *"we will not abandon you...but we have to be frank and realistic"*. In Module 2B, the Older People's Commissioner for Wales, Helena Herklots described in her written and oral evidence the level of distress caused by the letter and the approach to the elderly more generally. She stated in her oral evidence that issues pertaining to the use of DNACPR, together with a

"number of different things happened which, cumulatively, older people who were talking to me or talking to other older people which was being reported to me, there was certainly feeling that -- that sense of, yeah, just not being valued." [M2B 2/128/7-11].

91. In Wales it was made clear to healthcare professionals through various guidance documents and joint statements (INQ000226990; INQ000235489; INQ000252780; INQ000081000; INQ000300701; INQ000300106; INQ000227432; (INQ000283301) that it is unacceptable for DNACPR forms and Treatment Escalation Plans to be applied to groups of people of any description and that decisions must continue to be made on an individual basis according to need.

92. Notwithstanding guidance having been given to healthcare professionals, unacceptable practices surrounding DNACPR continued throughout the pandemic including medical professionals making decisions at speed without adequate or any discussion with patients and families (INQ000339027); care home managers being under pressure by healthcare professionals to sign wholescale DNACPR instructions on behalf of residents (INQ000319639_20). Striking evidence has been given by the Welsh bereaved of such concerns.

93. Professor Lockey of the Resuscitation Council UK (INQ000343994) gave evidence that DNACPR is intended to guide clinicians in event of cardiac arrest and should not impact on escalation of treatment, but it is often misunderstood by clinicians. In England, the RESPECT process has been introduced to mitigate these concerns and to represent a single comprehensive summary of personalised recommendations for a person's clinical care. There is no such plan to roll out RESPECT in Wales (notwithstanding it is being rolled out in each of the other four nations). Instead, Wales has an All Wales DNACPR Policy and a *"variety of forms"* addressing various aspects of advanced care planning and treatment escalation. Professor Lockey suggests that the absence of a nationally standardised process creates patient risk and recommends that the RESPECT process be adopted in all four nations.

94. The evidence of Anna-Louise Marsh-Rees [39/16/13 – 39/17/14] serves to highlight the patient risk described by Professor Lockey which is inherent in Wales's multi-form system. Ms Marsh-Rees explained:

Most of us were not consulted. And most of us didn't find out there even was one placed until we got hold of the hospital notes and that could be some months, even years, later. And then also the. confusion with the DNACPR and the treatment escalation plan. My dad's are contradictory to each other, the treatment escalation plan says he is eligible for CPR; his DNACPR says he's not. Neither of them are filled in completely, and, you know, we were told by the health board that they had tried to contact us, but that we were having our dinner. How they knew this, we've no idea, but they have subsequently apologised that they did not attempt to consult us on that.

95. In addition to Professor Lockey's recommendation, the Older Person's Commissioner for Wales has called for a review as to how the DNACPR decision process works in Wales and what improvements can be made.

96. The present lack of digitisation of DNACPRs and Treatment Escalation Plans in Wales renders wholescale audit virtually impossible. This perhaps explains (albeit does not justify) why there has been a failure by the Welsh Government to direct a robust audit of DNACPR decisions taken during the pandemic [31/134/1-13]. The lack of digitisation is unacceptable and should be rectified immediately. When asked about whether NHS Wales had started to create an electronic repository of DNACPR decisions, Judith Paget stated *"Work has begun to understand how that might be developed"* [31/131/5-6]. In response, the Chair rightly opined *"you obviously got plenty of evidence that things aren't going right and you need to do something and you've had the recommendation Mr Mills has put to you that that you say has been accepted by the Welsh Government about an electronic repository which might avoid these things happening and make life a great deal better for the families of people upon whom these notices have been put and indeed for the patients themselves. But when Mr Mills asked you what's been done to create it, you said the Welsh Government's accepted it but then you used this expression "Work has begun to understand how that might be developed". That doesn't sound very specific to me"*. CBFJ Cymru agrees that specificity and measurable actions are required.

ACCESS TO GENERAL PRACTITIONER SERVICES

97. Andrew Goodall initially denied any specific difficulties with patients using video consultation services that was rolled out in all GP practices in Wales (INQ000485721_0283 paragraph 738).

98. Many of CBFJ Cymru's members report that GPs were being hard to get hold of and were in fact not offering virtual appointments when they should have been available. Such concerns were widely reported in the press up to as late as September 2021 (INQ000343992_0004). In addition, the Public Services Ombudsman for Wales investigated several issues relating to the GP service in Wales (INQ000472302_0015-16), including a failure to provide virtual appointments for vulnerable individuals, and service failures in lack of face to face appointments.

99. When asked about these difficulties in evidence, Andrew Goodall accepted *"they were issues that we were made aware of"* but deflected responsibility stating *"The operational use of the systems were for every individual GP practices, they were supported by their health boards to implement that. We wanted to make sure that the platform was available at a national level to give that flexibility"* (31/110/5-10). Dr Goodall failed to identify what steps were taken by Welsh Government and NHS Wales to mitigate the issues identified.

100. Further, the Welsh Government failed to conduct a formal impact assessment for digital inclusion and consideration of recommendations on the elderly, disabled, and those with language/digital access issues was not always explicit in the submission of advice (INQ000485721_0288 paragraph 754). Given these considerations had been part of the Wales strategy for digital health set out in 2015 - 5 years before the pandemic – so should have been easily identified and placed front and centre of the advice. Dr Goodall accepted *"they should have, you're right, the previous strategies were there"* (31/111/6-7).

SHIELDING

101. The shielding plans for the United Kingdom were developed by the CMO's of the four nations. The Inquiry has heard evidence that notwithstanding the clear difficulties in identifying those cohorts of patients who should shield, the data systems are still not in place to enable that process to happen swiftly and accurately (Frank Atherton 30 September 2024 page 77). Sir Frank was very vague as to specific actions that the Welsh Government

is taking to strengthen those systems including any steps to align the primary care and secondary care database systems. The Inquiry has heard evidence about 13,000 of the initial 91,000 shielding letters going to the wrong address; errors in respect of categories of individuals added to the list; delays in sending letters to relevant cohorts of patients; and lack of clear guidance being provided, particularly when the Welsh Government's approach to shielding diverged from the rest of the UK in the Summer of 2020. Ms Marsh-Rees also gave evidence of erroneous information being contained within shielding letters. Ms Marsh-Rees's described that her father received a shielding letter in October 2020 which *"arrived the day after my father died that was (a) telling him he didn't need to shield, which seemed completely baffling because obviously he was 85 with comorbidities, but not only that you should only take a PCR test if you had symptoms, but only with these three symptoms, and that it was pointless to do one if you didn't have symptoms, which I -- we know in October 2020 that everyone knew that, you know, you could test positive and be asymptomatic"* (39/9/1-10). To compound these issues, the Welsh Government has not undertaken an assessment of effectiveness of shielding programme (13/83/16-22) in order to identify what lessons could be learned for the future.

COMPASSIONATE CARE AND DIGNITY IN DEATH

102. The evidence gleaned from this Module highlights that many individuals were denied compassionate care and dignity in death.

103. A number of CBFJ Cymru members reported difficulties in seeing and/or communicating with their loved ones in hospitals and the clinicians who were purporting to care for them. Where communication was forthcoming from clinicians, it was not always compassionate in nature. Ms Marsh-Rees described being panicked and distressed, pleading with a clinician to give her father oxygen to which the doctor replied, *"That ship has sailed"*. Ms Marsh-Rees remarked *"**words matter**, the way the words are written, the way that words are said. Things like that are just, you know, it haunts my sister and I. That -- it's just so casual..."* (emphasis added) [39/14/18-21].

104. Many patients spent their final moments on soleless hospital wards in the company of strained and frightened staff; deprived of contact with their loved ones, scared and alone. Ms Marsh-Rees stated:

most of our loved ones…were older. They led very silent, quiet deaths...it's almost death by indifference…nobody communicated to them, nobody told them what was happening, they didn't have communication with their loved ones. And I really do think we need to ponder on…that element of it. It's those quiet silent deaths that are the real tragedy [39/13/8-16]

105. The Inquiry has also heard evidence that the bodies of some individuals were lost temporarily by the morgues, with no apology offered to distraught loved ones and belongings of the deceased, if not already lost, having been presented back to family members in clear plastic bags, often covered in urine or blood, without warning [39/17/23-39/19/2].

106. Finally, the Inquiry has heard evidence that employees in Aneurin Bevan University Health Board (then under the leadership of Judith Paget) were given permission to take photographs of patients, both living and dead, for the purposes of publication. The photographs included photographs of people on ventilators and bodies in body bags. Impacted members of CBFJ Cymru consider that these were highly sensitive images of seriously ill, vulnerable and dying patients and they seriously question the morality of taking photographs and how valid consent could have been reliability obtained in such circumstances. The images have resulted in re-traumatisation for family members who have been left deeply upset and angry that authorisation was given. In the words of Sam Smith-Higgins (INQ000486273_0011 paragraph 30) '*It beggars belief why the health board thought it would be appropriate to permit employees to use the suffering endured in the pandemic…whilst people were dying…'*. The hurt is further compounded by the perceived lack of accountability of decision-makers. As Anna-Louise Marsh-Rees (INQ000343992_0011 paragraph 41) said '*There appears a lack of willingness to accept that this ought not to have happened.'*.

107. Where was the dignity for the deceased? Where was the compassion for the bereaved?

108. In brief: words matter and compassion matters.

RECOMMENDATIONS

Urgent Interim Recommendation

109. The evidence in Module 3 has overwhelmingly supported the need for adequate IPC controls to limit airborne transmission of Covid-19, yet the current guidance still only requires FFP3 masks to be worn when AGPs are performed. The IPC Guidance is "*outdated*" and "*are in urgent need of updating*" [INQ000474276_0087].

110. With this in mind, CBFJ Cymru considers that the Chair should made an interim recommendation for an urgent review and revision of the Infection Prevention Control ('IPC') Guidance to ensure that it reflects the evidence of aerosol transmission and appropriate risk mitigation e.g. FFP3 masks, ventilation and segregation.

Other Recommendations

111. In light of the foregoing, CBFJ Cymru advance the following submissions for the Inquiry's consideration:

- Transparency, honesty and stakeholder engagement on the development and implementation of IPC guidance;

- Welsh Government to ensure that the healthcare system in Wales is adequately resourced on day-to-day and emergency bases;

- Welsh Government and NHS Wales to commission a transparent and independently audited review of the structure of the NHS in Wales with a view to establishing clearer divisions of responsibility between Welsh Government and NHS Wales and defining the leadership role of Welsh Government;

- Welsh Government and NHS Wales to commission a transparent and independently audited review and risk assessment of the condition of the NHS Wales Estate to better support the implementation of Infection Prevention Control measures. In particular, this should include a review of ventilation capabilities and recommendations for the implementation of appropriate ventilation across the NHS Estate including more widespread use of HEPA filters and CO2 testing;

- Welsh Government and NHS Wales to commit to measurable targets for reducing nosocomial transmission generally i.e. by a certain percentage by a particular date. IPC guidance generally to be reviewed to ensure appropriate emphasis is placed on the importance of appropriate PPE and regular staff and patient testing to mitigate against nosocomial transmission;

- Welsh Government and NHS Wales to provide plans setting out how it intends to keep the clinically vulnerable safe when using hospitals;

- Welsh Government and NHS Wales to commission a transparent and independently audited review of critical care capacity in Wales underpinned by a clear methodology for measuring capacity based on factors beyond the physical bed space e.g. availability of suitability qualified staff and availability of medication and equipment;

- Welsh Government and NHS Wales to improve the data infrastructure in Wales to ensure meaningful data collection, analysis and sharing;

- Welsh Government and NHS Wales to formulate a robust pandemic plan with provision for prompt deployment of properly resourced scalable measures in the event of emergency e.g. PPE stockpiles; established supply chains for PPE, testing, medication and equipment; and staffing resilience etc;

- Welsh Government and NHS Wales to establish and effective system for co-ordination across the NHS Wales network;

- Welsh Government to work with the other four nations to strive for alignment and clear public health messaging across the four nations. This should include mechanisms for ensuring that primary and secondary care services are clear in public messaging and advice given to the public;

- Welsh Government and NHS Wales to establish robust systems for consultation between clinicians patients and family;

- NHS Wales to introduce mandatory bereavement support training for all staff;

- Welsh Government and NHS Wales to conduct an audit of DNACPR decisions made during the pandemic;

- Welsh Government and NHS Wales create an electronic repository of DNACPR/Advance Care Planning/Escalation of Care documentation;

- DNACPR/Advance Care Planning/Escalation of Care etc documentation to be accessible via the Welsh Clinical Portal to ensure that relevant documents are linked.

CONCLUSION

112. CBFJ Cymru is grateful to the Inquiry for supporting its ongoing participation in the Inquiry.

113. CBFJ Cymru commends the inclusion by the Inquiry in Module 3 of the oral evidence of representatives of the bereaved family groups. Hearing directly from bereaved family members has been vital to ensuring that the impact of Covid-19 in Wales is fully understood and to ensure that the significance and magnitude of the issues under investigation in the Inquiry are not lost. The bereaved must remain at the heart of this Inquiry.

114. CBFJ Cymru looks forward to receiving the Module 3 report which it hopes will contain constructive and measurable recommendations across the range of issues covered within this written submission.

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20 DECEMBER 2024

Covid-19 Bereaved Families for Justice Cymru

Written closing statement for Module 4 of the UK COVID-19 Inquiry – vaccines and therapeutics

Introduction

1. A priority of the Covid-19 Bereaved Families for Justice Cymru group (the group) is to scrutinise whether the Welsh Government discharged its duty to protect the lives of people in Wales. This closing statement identifies key concerns of the group in relation to this duty, and is focussed on the delivery of vaccinations in the first few months of the programme to the most vulnerable people in Wales.

2. The group submits that when considering these issues, it is important to recall just what a devastating period this was, with care homes in Wales experiencing 465 Covid-19 related deaths of residents in January 2021 alone, and at times as many as 20 deaths a day.

3. Time was of the essence for many vulnerable people in Wales, as powerfully described by the group's co-lead, Sam Smith-Higgins, who told the Inquiry in her oral evidence [Day 2-15.01.25/115:21-117:22] about her fears for her 73-year-old father, who was admitted to hospital in early January 2021 for cancer related treatment, and was immune suppressed and vulnerable. Ms Smith-Higgins made efforts to secure a vaccine for her father prior to his admission but was told this wasn't possible. Tragically, just three weeks after being admitted to hospital, he died from a Covid-19 infection acquired in hospital.

4. A major concern of the group was the decision of the Welsh Government to intentionally delay and stagger the provision of vaccines to the most vulnerable cohorts, as set out from paragraphs 6 to 20 below. And this decision was all the more indefensible because of the appalling level of nosocomial infections within Welsh hospitals and care homes over the period of the delay (during which vulnerable people ought to have been prioritised), as demonstrated by the "Update on COVID-19 Nosocomial Transmission Group and current priorities" (INQ000227307) from February 2021, including the following statements and data:

> "*Nosocomial transmission of COVID-19 is unfortunately widespread in health boards/ Velindre Trust across Wales. Hospital transmission of COVID-19 has*

been a major safety and quality concern for all NHS organisations since the start of the pandemic." (INQ000227307/1).

"*PHW data from 14/2/21 shows that 1002 patients were in Welsh hospitals with a positive COVID-19 test, and 529 of these (53%) were classified as hospital onset."* (INQ000227307/2).

"…notifications to CIW of confirmed cases in staff or residents in care homes were higher during the second wave of the pandemic. Notifications of confirmed cases peaked in the week ending on 11 January 2021" (INQ000227307/3).

5. Regrettably, the position in Wales has not improved, with data published by Public Health Wales showing as of 09 February 2025, some 83% of inpatient Covid-19 cases in Wales were the result of hospital-acquired infection.

<u>The decision of the Welsh Government to deliberately slow the rate of vaccine delivery and its failure to vaccinate in accordance with Joint Committee on Vaccination and Immunisation (JCVI) priority cohorts</u>

6. The JCVI advised that those living in residential care homes for older adults were at a high risk of exposure to infection and at higher clinical risk of severe disease and mortality, and that given the increased risk of outbreaks, morbidity and mortality in these closed settings, they were at very high risk, and should be the highest priority for vaccination. Accordingly, they were designated as cohort 1 within the priority groups.

7. However, the Welsh Government did not follow this advice, and Vaughan Gething, the former Minister for Health and Social Services decided on 25 November 2020 that the Pfizer vaccine would not be used in care homes for the first 4 weeks of delivery (paragraph 95 of the witness statement of Vaughan Gething [INQ000493687/23]).

8. This decision was taken following Ministerial Advice to the Minister for Health and Social Services (copied to the First Minister, at that time Mark Drakeford) [INQ000361639], that included the following information:

    12. *Given the constraints around transportation of the Pfizer vaccine to care homes described in paragraphs 5 to 8, it is recommended that the vaccine is not used in care homes for the first 4 weeks of delivery.*

    …

    17. *The incidence and spread of coronavirus in Wales and the UK as a whole is an ongoing risk to public health. A written statement on the 17 November*

confirmed that while there will be limited supplies of this vaccine at first, it will be offered to those at highest risk and that priority for initial distribution of any new vaccine will be determined in accordance with advice from the Joint Committee on Vaccination and immunisation. Care home staff and residents are in Cohort 1…

9. On 18 January 2021, the former First Minister, Mark Drakeford, made a public statement in response to criticisms that the Welsh Government was behind other UK nations, and explained that, "*The sensible thing to do is to use the vaccine you've got over the period that you've got it for so that your system can absorb it, they can go on working, that you don't have people standing around with nothing to do*". [INQ000381306/2]

10. In the witness statement of Mr Drakeford to the Inquiry [INQ000474420/30] this public statement is explained as follows:

> *"On 18 January 2021, during a BBC Radio 4's Today programme I was asked about the vaccine roll out in Wales and the suggestion that Wales had vaccinated fewer proportion to its population than other nations of the UK. I explained that there was a very marginal difference in the vaccination statistics but in any event, I explained that the supplies of the Pfizer vaccine had to last until the beginning of February and would not be used all at once. I explained that it would be logistically damaging to use the vaccine all in the first week and the sensible thing to do was to vaccinate over the period that we had to vaccinate, so that the system could absorb it. At no time was the Pfizer vaccine withheld. All Health Boards were received doses of Pfizer which were successfully deployed in a manner to minimise wastage, which at that time was less than 1%. I committed to vaccinating all four priority groups by the middle of February and this was achieved."*

11. This statement is incorrect in two material respects:

    a. First, the statement, "*at no time was the Pfizer vaccine withheld*" is not correct. It was in fact deliberately withheld from care home residents by a decision of the Minister for Health and Social Care, Vaughan Gething, on 25 November 2020.

b. Second, the statement, "*I committed to vaccinating all four priority groups by the middle of February and this was achieved*" is also not correct. As set out below at paragraphs 14 and 15, by 10 February 2021, only 78% of the first priority cohort (care home residents) had been vaccinated, which rose to only 82% by 16 February 2021.

12. Further it was well known that Wales was pursuing a different approach from other UK countries, with staggered delivery, and that it was not following the advice of JCVI on priority cohorts, as can be seen from the Cabinet Office Meeting minutes of 12 January 2021 [INQ000088889], that read:

> "*… 300,000 doses had been delivered to Wales, but short of 90,000 had been used so far. The press had picked up that this was down to the Welsh Government. It would be useful to have regular publication of how many vaccines had been delivered. The Welsh Government's approach was slightly different to other nations' as it had prioritised NHS staff for the Pfizer vaccine.*"

13. While vaccinations in Wales commenced on 8 December 2020, by 26 January 2021 only 67% of care home residents had been vaccinated (confirmed in an oral statement of the Welsh Government by Vaughan Gething on this date [INQ0004928860]).

14. This rose to 78-79% by 10 February 2021 (as set out in the minutes of a meeting of the Four Nation Senior Responsible Owners for the Vaccination Programmes from that date, contained within an email of 12 February 2021 [INQ000412273]).

15. By 16 February 2021, well over two months after vaccination commenced, only 82% of care home residents in Wales had been vaccinated (as set out in the Welsh Government's Vaccinations Update [INQ000410143]). Whilst at first blush this might seem a high proportion, in fact it was significantly below some of the other Phase 1 priority cohorts in Wales (such as those aged 70 and over).

16. Further, the update of 16 February 2021 also demonstrates (through the graph at INQ000410143/2 with the yellow line denoting care home residents) that progress in vaccinating care home residents in Wales during February 2021 had almost flatlined.

17. The anger and confusion at the decisions of the Welsh Government to delay the vaccination of vulnerable people was reflected in the oral evidence of Ms Smith-

Higgins, on behalf of the group, on 15 January 2025, as follows [Day 2-15.01.25/116:6-19]:

> "*the vaccinations had started coming out on 8 December, and I was a carer for an 85-year old, my mother, so I expected her to be vaccinated relatively soon, but as December went through, I was tweeting like mad everybody, MPs, MSs, head of NHS, saying: What is going on? Why hasn't my mother been vaccinated? And it soon became apparent that actually, in Wales, they were focusing on the healthcare workers and not aged or the most vulnerable. By 11 January, Cardiff and Vale health board tweeted that up to date, up to 11 January, they had vaccinated 12,300 people, of which 69 were in care homes and only 75 were over 80.*"

18. The group wishes to make clear that they take no issue with the prioritisation of frontline healthcare workers, as advised by the JCVI, but this was not what happened in Wales, with significant numbers of administrative staff vaccinated before the vulnerable. Ms Smith-Higgins refers in her witness statement [INQ000413805/5] to one such example: a relative in her 50s, with no underlying health conditions, who worked in an administrative department of one of the Welsh Health Boards, and who received her vaccination in December 2020.

19. The concern and anger about this issue was also amplified by the history of neglect of care homes in Wales during the pandemic. This was epitomised by the evidence of Mark Drakeford in Module 2B, when he told the Inquiry in March 2024 that, "*There is no single register of where every care home in Wales is located*" [M2B/Day 11-13.03.24/211:15-16], which begs the question, how was vaccination progress being managed and monitored among this most vulnerable priority group in Wales, when the Welsh Government didn't even know of their existence?

20. The group asks that the Inquiry carefully considers the circumstances in which the vaccination of priority cohorts was deliberately delayed and staggered in Wales, and highlights the following further evidential features and concerns:

    a. Despite holding the position of Senior Responsible Owner for the Vaccination Programme in Wales since June 2020, these issues are not addressed within the witness statement of Dr Gillian Richardson [INQ000501330], who was the sole Welsh witness to give oral evidence

during the Inquiry hearings, and despite the Ministerial Advice of 24 November 2020 being cleared by Dr Richardson [INQ000361639/1).

b. The decision on 25 November 2020 not to vaccinate people in care homes was taken because of concerns about the refrigeration requirements of the Pfizer vaccine. However, these concerns had been known since at least 25 August 2020 and contingencies should have been developed and put in place by the Welsh Government. Paragraph 67 of the witness statement of Dr Gillian Richardson states [INQ000501330/18]:

> "*...on 25 August 2020, it was recorded that there was a significant risk of insufficient freezer storage being available to store a vaccine requiring a temperature of -70 degrees centigrade, should such a vaccine receive regulatory approval.*"

c. The risks to care home residents were not negligible – they were the highest priority cohort as made clear in the advice of the JCVI (above at paragraph 6) because they were at very high risk. In this context, it is unthinkable that their vaccinations should have been intentionally delayed for want of a logistical solution that other UK countries were able to deploy.

d. To further emphasise how important it was to adhere to the JCVI priority cohorts, the evidence of Professor Wei Shen Lim at the Inquiry's hearings [Day 8-23.01.25/89:7-90:6] was that,

> "*the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age care home, we would protect one life. The same number needed to vaccinate to prevent one person from dying in a 65-year old cohort was 1,000, and of the number needed to vaccinate -- to prevent one life -- save one life in the 50-plus cohort is 8,000. So by the time we get to children and young people who have no underlying health conditions, then the number needed to vaccinate to prevent one adverse outcome -- - clinical outcome, not safety outcome -- is in the many tens of thousands.*"

e. This also brings into question the policy of the Welsh Government to move to next priority cohorts when only 50% of a higher cohort had been vaccinated. As set out at paragraph 262 of the witness statement of Dr Gillian Richardson [INQ00050130/57]:

> "*Wales also permitted commencing issuing invitations to the next JCVI ordered priority cohort group when at least 50% of the cohort above had been invited, this capturing those willing to attend as swiftly as possible and enabling the mass vaccination clinics to be used to maximal efficiency.*"

The group suggests that it is this same, misguided approach, that saw NHS back-office staff vaccinated before the vulnerable and asks the Inquiry to consider the extent to which volume of vaccinations (for statistical and presentation purposes) was pursued over safety.

f. In the same vein, the group notes the absence of meaningful challenge and scrutiny of government within Wales, an example of which is the largely uncritical report of Audit Wales on the rollout of the vaccination programme in Wales from June 2021 [INQ000066528]. This report inaccurately finds that the Welsh Government adopted the JCVI prioritisation guidance [INQ000066528/4], makes the doubtful claim (see paragraphs 29 to 33 below) that the Vaccination Strategy for Wales set out the expectations for prioritisation and delivery of the vaccine [INQ000066528/9], and makes no mention of the decisions to delay vaccinations in care homes, and to stagger vaccination of other vulnerable groups. The fulsome praise of the Welsh Government by Audit Wales is set out in detail at paragraphs 147-151 of the witness statement of Dr Gillian Richardson [INQ000501330/35].

g. The Welsh Government has complained within the Inquiry proceedings (at paragraphs 83 and 84 of the witness statement of Dr Gillian Richardson [INQ000501330/22] and elsewhere) that Wales should have received a higher number of vaccinations, because while vaccinations were allocated according to the Barnett formula (based on Wales having 4.72% of the UK population in 2019 [INQ000396131]), the population of Wales was older and had greater healthcare needs than the wider UK population, and therefore required a higher percentage of supply for the priority cohorts. The group made the point during its oral closing statement on 30 January 2025, that it considered this complaint to be politicking by the Welsh Government, and that the governments of Northern Ireland and Scotland expressed no such concerns. The group further notes that the position of the Welsh Government on the Barnett formula is inconsistent with its policy of delaying and staggering the provision of vaccines to the most vulnerable groups.

h. The group wishes to know how many deaths could have been prevented if the Welsh Government had not delayed the vaccination of vulnerable groups between December 2020 and February 2021.

Over reliance on a small number of mass vaccination centres despite the geographical and demographic challenges of Wales.

21. The group is also concerned at the decision in Wales to heavily rely on delivery through larger vaccination centres. This decision is particularly difficult to understand given the geography of Wales with many rural and remote communities, and the demographic of Wales, which as explained by Dr Richardson in her witness statement, is an older population with greater healthcare needs than in other parts of the UK.

22. The group's co-lead, Sam Smith-Higgins, told the Inquiry in her oral evidence to the Inquiry [Day 2-15.01.25/121:17-122:7], that the mass vaccination centres in Wales covered huge geographical areas, requiring lengthy journeys by car, or for those without a car, lengthy journeys involving several buses. She told the Inquiry:

> *"for people who have been shielding for months and months and months, to suddenly have to take an hour-and-a-half journey within the same health board to then stand outside for an hour-and-a-half queuing to get into a sports centre, it wasn't the best thought out".*

23. The group would like to know why the Welsh Government used this model - a person to vaccine model, rather than vaccine to person model - when it would so obviously disadvantage those who were vulnerable and/or could not travel.

24. The group believes that trusted healthcare professionals, such as GPs and community pharmacists, who are embedded within communities and easily accessible, were insufficiently utilised by the Welsh Government in the delivery of vaccines compared with other UK countries. Most people prefer to access their community based primary healthcare services such as GP practices and community pharmacies for vaccination, and these services also play an important role in overcoming barriers to vaccination within their communities. The group believes that this was a missed opportunity by the Welsh Government.

25. The Oxford AstraZeneca vaccine became available at the beginning of January 2021 and was widely used in Wales from this time, as can be seen from a Wales Covid-19 Vaccination Programme Daily Situation report from 29 January 2021 [INQ000505456]. This Daily Situation Report records that some 138,000 AstraZeneca vaccines had been delivered by the end of January 2021.

26. The Ministerial Statement of the former Minister for Health and Social Care, Vaughan Gething, made on 4 January 2021, described the AstraZeneca vaccine as a "*gamechanger*" [INQ000388300]. The statement said as follows:

> "*Members will be aware of the widely reported benefits of this latest vaccine - it is cheaper and supply will be more plentiful. However, crucially, it presents significantly fewer logistical challenges than the Pfizer/BioNTech vaccine, with storage at normal fridge temperatures. As NHS capacity continues to build over the coming weeks, we will be able to get the vaccine to where it is needed in every part of Wales. Much more flexible and mobile deployment models will be activated. Every care home will be within reach and this priority group will be a key focus for the NHS over the coming weeks.*"

27. The group believes that the difficulties of storing and transporting the Pfizer vaccine, while real, are too often relied upon to explain away poor performance or justify poor decisions; for example, the overreliance on mass vaccination centres and the delays in vaccinating vulnerable people.

28. Given the widespread availability of the AstraZeneca vaccine, in the quantities described in paragraph 25 above, the failure to vaccinate a care home population of approximately 16,000 residents, constituting the most vulnerable people in society, by mid-February 2021, is a striking failure.

Strategies and milestones

29. The group's experience of the Welsh Government is that it is strong on rhetoric and weak on delivery, and they submit that this was also a feature of the delivery of the vaccination programme.

30. The Vaccination Strategy for Wales [INQ000410079] was published on 11 January 2021, and included three key milestones, the first of which was:

"*Milestone 1 – by mid February – cohorts 1-4. Subject to supply, our aim is to offer vaccination to all care home residents and staff, frontline health and social care staff, those 70 years of age and over, and clinically extremely vulnerable individuals.*"

31. In respect of this milestone, paragraph 153 of the witness statement of Vaughan Gething [INQ000493687/37] states:

> "*By 12 February 2021 the first milestone in the Vaccination strategy for Wales had been achieved with the vaccine having been offered to all those in the priority groups 1-4. Wales was the first of the four UK nations to reach this key milestone.*"

32. There are many things wrong with using such a meaningless metric as the number of invitations issued, including:

    a. at the date of this 'achievement', only 78-79% of care home residents in Wales had actually received their first dose of the vaccine.
    b. despite claiming, "*Wales was the first of the four UK nations to reach this key milestone*", its performance in fact lagged behind other nations, with England having vaccinated 93% of care home residents by 14 February 2021 [INQ000421393/2].
    c. measuring achievement in such a superficial way takes no account of the difficulties experienced by the many who did not receive their invitation, or who received an invitation but experienced difficulties booking and travelling to an appointment, or, as in the case of many care home residents, those who were still waiting for their vaccination to be administered at the point the Welsh Government announced the milestone had been met.

33. However, its lack of substance is best illustrated by the experience of Sam Smith-Higgins. As she said in her witness statement [INQ000413805/5], an invitation was sent to her father one week after his death, no doubt an invitation which contributed to the achievement of the milestone announced by the Welsh Government.

<u>Other concerns</u>

34. There were also problems with communications, including invitation letters for first and second doses being sent in an identical form which caused confusion, and concerns about the clarity of the invitations issued, which used English and Welsh language interchangeably over several pages of information, making it difficult to understand.

35. In respect of unpaid carers, the group notes the oral evidence of Dr Richardson [Day 10-28.01.25/96:7-15], that unpaid carers in Wales were able to self-certify in order to be vaccinated. However, this was not the personal experience of Ms Smith-Higgins, [INQ000413805/10] who is an unpaid carer for her mother, and it is also at odds with the Audit Wales report which states [INQ000066528/15], "*There have also been challenges identifying unpaid carers who have previously not been recorded on any system.*" It is also contrary to the evidence from the chair of the JCVI, Professor Wei Shen Lim, that in a mass vaccination programme, the main means of asking people to attend for vaccination should not be self-identification [Day 8-23.01.25/108:10-12].

Conclusion

36. In conclusion, the group asks the Inquiry to consider and, where appropriate, determine the following issues and concerns:
    a. Why vaccinations in Wales were intentionally delayed for vulnerable groups and whether these decisions led to avoidable injury and death, particularly having regard to the evidence of Professor Wei Shen Lim that the vaccination of 20 people who are resident in an old age care home, would protect one life.
    b. Why the Welsh Government failed to follow the JCVI prioritisation cohorts, including the delay and staggering of the first four cohorts, including the widespread vaccination outside of the prioritisation cohorts (e.g., NHS administrative staff), and the policy of proceeding to vaccinate the next priority cohort while only 50% of a higher priority cohort had been vaccinated (again, with regard to the evidence of Professor Wei Shen Lim on the importance of vaccinating the most vulnerable first).
    c. Whether the justification provided within the Ministerial Advice of 24 November 2020, and subsequent decision of Vaughan Gething on 25 November 2020, that in respect of the obligation of the Welsh Government to take preventative operational measures to safeguard the lives of Welsh citizens, the decision to delay the vaccination of people in care homes was justifiable [INQ000361639/5-6]), having regard to the knowledge from at

least August 2020 of the refrigeration requirements of the Pfizer vaccine, the evidence heard by the Inquiry that the vaccination of 20 care home residents would protect one life, and the high level of Covid-19 related deaths of some 465 care home residents in Wales in January 2021 (see paragraph 2 above).

d. Whether there was an overreliance in Wales on mass vaccination centres at the expense of more local services.

37. Finally, in respect of the use of WhatsApp messages by the Welsh Government, the group submits that it is abundantly clear from information disclosed in Module 4, that this medium was in widespread use for operational and decision-making purposes. For example, the WhatsApp messages between the Senior Responsible Owners of the Vaccination programmes in each of the UK countries [INQ000477804] demonstrate the effective collaboration and working relationship of this group, over 49 pages and approximately 1,500 messages.

38. Similarly, the former Minister for Health and Social Services, Vaughan Gething, was part of a Ministerial WhatsApp group with Matt Hancock and other Ministerial counterparts [INQ000095819].

39. For present purposes the group simply restates its position, namely that:

    a. The claims of the Welsh Government that WhatsApp messages were not used to conduct official government business are clearly unsustainable.
    b. Such messages over the period of the pandemic are relevant to the Inquiry's Terms of Reference.
    c. Members of the Welsh Government deliberately and systematically destroyed these messages to avoid public scrutiny, including by the Inquiry.

13 January 2025

COVID 19 INQUIRY

MODULE 5:

PPE AND PROCUREMENT

WRITTEN CLOSING STATEMENT

OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU

INTRODUCTION

1) From 3 to 27 March 2025, the Inquiry heard evidence on 'Procurement and distribution of key healthcare equipment and supplies' (Module 5). Of the 48 witnesses who attended to give evidence, just four gave evidence on issues specific to Wales: Alan Brace, Andrew Slade, Jonathan Irvine and Richard Davis. Their evidence lasted just over 4 hours. CBFJ Cymru was allocated a total of 40 minutes to question them. Of course, the evidence of some of the remaining 38 witnesses touched on the devolved administrations. But not in any detail. And CBFJC was permitted questions of just two of the 38 - Rosemary Gallagher (RCN) and Matt Hancock - for a total of just 10 minutes. Crucially, and notwithstanding the requests of CBFJ Cymru, at no stage did the Inquiry hear from the former First Minister, the Rt Hon Mark Drakeford, nor Mr Vaughan Gething, the Minister for Health and Social Care in Wales over the majority of the relevant period (Jan 2020-May 2021) who had ultimate responsibility to ensure healthcare workers and the people of Wales had the PPE and healthcare equipment they needed.

2) In such circumstances, it is inevitable that gaps remain in the Inquiry's understanding of the issues faced in Wales with respect to procurement and distribution of PPE and other key healthcare equipment. That gaps remain in the Inquiry's understanding is not a criticism of the Chair: in the time available, there could be no realistic hope of unpacking the nature and extent of the failures in Wales. But the point nevertheless remains: if there is at best only a partial understanding of failures in Wales, how can the CBFJ Cymru, their members, and the people of Wales more widely, have any confidence the Welsh Government will reflect on its failures and learn lessons for the future?

3) The issue of 'lessons learned' and recommendations are addressed in more detail at the end of these closing submissions. In these introductory remarks, we note the CBFJ

Cymru's concerns as to recommendations and lessons learned. The signs are ominous for Wales. The evidence of the Welsh witnesses – both orally and in writing – appears to reflect the belief among those in positions of responsibility in Wales that the roots of their problems lie beyond the Welsh borders, either in Westminster or further afield. The CBFJ Cymru are concerned that there has been little reflection, let alone constructive criticism, of what went wrong in Wales.

4) The Inquiry should not be taken in by statements that Wales did not experience the same problems as England. Such statements have the regrettable appearance of self-congratulation. Nor should it be taken in by statements extolling the virtues of small governance. Such statements have the regrettable appearance of idealism: in reality, as we have seen, "small" does not necessarily translate to good, effective and efficient governance.

5) Against that background, some (not all) of the most problematic issues – and problematic gaps in understanding – are addressed below in these closing submissions.
    a) Pandemic stockpiles
    b) PPE and equipment in hospitals
    c) PPE and equipment in care homes
    d) Ventilators, oxygen and CPAP (other equipment)
    e) IPC Guidance on FFP3 masks
    f) Lessons learned
    g) Conclusion

PANDEMIC STOCKPILES

Introduction

6) After some introductory remarks, this section on Wales' 'pandemic stockpile' covers:
    a) The failure to implement the recommendations of exercises
    b) Extent of the deficiencies: comparisons with the other UK nations
    c) Addressing the deficiencies: Just-In-Time contracts and re-testing of FFP3 masks
    d) Reasons for deficiencies in the Wales' stockpile
    e) Conclusion

7) The Inquiry will be considering whether the stockpiles of key healthcare equipment and supplies were adequate to respond to the Covid-19 pandemic [**LoI 1 §§1-3**].

8) The Wales stockpile was not adequate to respond to the Covid 19 pandemic.

9) The Welsh Government maintained a stockpile in collaboration with the other UK nations and in accordance (primarily) with the Pandemic Influenza Preparedness Programme (PIPP) prepared in 2011. This meant it maintained a range of medical countermeasures and consumables, such as FFP3 respirators, surgical masks, eye protection, gloves etc. In addition to the stockpile, Wales also had UK wide contracts in place for additional stock to take the PIPP to 15 weeks of supply if required (the 'Just-In-Time' contracts).

10) It is important to note at the outset that the stockpile was the responsibility of the Welsh Government. Witnesses who gave evidence to the Inquiry appeared to show worrying confusion over this important point. Mr Brace (Welsh Government) suggested it was the responsibility of the NHS Wales Shared Services Partnership ("NWSSP") to ensure stock was monitored and fit for purpose [Brace; 6/180/17]. In other respects, he suggested it was the responsibility of the UK Government: the "plan for the PIPP stockpile was the responsibility of the UK government" [Brace; 6/191/13]; when the stockpile was down to 4 weeks, his "biggest concern was about getting clarity and assurance from the UK government they could fulfil their obligations under the emergency plan, and that proved exceptionally difficult…" [Brace; 6/191/1-8]. By contrast, Mr Irvine, director of procurement at NWSSP, understood that the stockpile was the responsibility of the Welsh Government [Irvine; 14/109/10-14/111/8]. This is consistent with the evidence of Mr Hancock, who reminded the Inquiry when asked specifically about the responsibility for the Welsh stockpile, that health was a devolved matter and the stockpile was accordingly the responsibility of the Welsh Government [Hancock;11/145/13].

11) The Wales stockpile was seriously deficient in the following ways:
    a) The quantities of stock held were woefully inadequate to withstand a pandemic.
    b) The stockpile had not been maintained and significant quantities of the equipment held within the stockpile was out of date, particularly FFP3 respirators.
    c) The plan to supplement the stockpile through Just-in-Time contracts was flawed, and these arrangements collapsed in the face of global competition,

which the CBFJ Cymru submits was entirely predictable and ought to have been foreseen.

The failure to implement the recommendations of exercises

12) Between 14 and 20 October 2014, the Welsh Government conducted a pandemic flu exercise, Exercise Cygnus, and in October 2016 produced a report, "Exercise Cygnus – Wales De-Brief Report" [INQ000187149_0001].[1] It is to be noted that NWSSP had been in operation for some years by this stage (since 2011).

13) This report contains the following objectives, observations and recommendations:
    a) "The workshop considered what countermeasures would be made available from the national stockpile and the mechanisms for distribution across the NHS in Wales and the mechanisms for local distribution across the NHS in Wales. The morning session...raised awareness of the consumables, antivirals and antibiotics held in the national stockpile. In the afternoon, delegates had the opportunity to work through the Cygnus scenario and were able to explore the national and local arrangements for each of the countermeasures...It was acknowledged that once a pandemic is threatened, the operational details to secure effective and efficient distribution across Wales would be quickly put into place." [INQ000187149_0003]
    b) Objectives for the day included:
        i) "To explain why particular products are held within the national stockpile"; and
        ii) To explain the National planning arrangements for storage and deployment." [INQ000187149_0003]
    c) Recommendation 2 - "All organisations to ensure there is sufficient awareness within their organisations of what is held within the Welsh National Stockpile and how these would be distributed to them." [INQ000187149_0004]

14) Despite this focus in Exercise Cygnus on the Welsh National Stockpile and the awareness of its importance, much of the stock of FFP3 respirators held within the stockpile had expired. The stocktake of the Welsh National Stockpile performed in February 2020 [INQ000300270] records that out of a total number of 929,600 FFP3

[1] Document disclosed in Module 1

respirators held in the Welsh stockpile at the outset of the pandemic, only 59,600 (less than 7%) were in date.

15) This out-of-date stock was comprised of two groups of stock with expiry dates of 13 October 2016 and 1 August 2019, a position that was regularly reported to and known by the Welsh Government, as confirmed by Jonathan Irvine of NWSSP in his oral evidence to the Inquiry [Irvine; 14/111/1-24].

16) The cost of the FFP3 respirator stock held in the stockpile was £1,764,920 (as recorded within INQ000300270) and while not an insignificant sum, CBFJ Cymru submits that an in-date stockpile of this life-saving equipment ought to have been maintained, and that the failure of the Welsh Government to do so requires careful scrutiny.

17) Another area in which the Welsh stockpile was seriously deficient was long sleeved gowns, and of the target stock of 573,600, Wales had zero in stock - not a single surgical gown. Indeed, it is to be noted that when surveyed in February 2021, doctors in Wales identified the availability of FFP3 respirators and surgical gowns as key areas of concern [INQ000214235_0031].

18) Further, despite the focus in Exercise Cygnus on ensuring each organisation was aware of "how [the Welsh stockpile] would be distributed to them" [INQ000187149_0004], this plainly did not happen. Witnesses from Wales consistently acknowledged that there was a lack of communication and understanding of how, and to where, stock would be distributed during the pandemic.

Extent of the deficiencies: comparisons with the other UK nations

19) The Inquiry has heard evidence that the pandemic stockpiles were deficient in all four nations in the UK. However, this should not mask the extent of the failures in Wales. Again, the issue is most marked in respect of FFP3 masks.

20) By 12 March 2020, a DHSC email records that "Wales are in the most challenging position" of the 4 nations [INQ000551495_0002]. By that stage, Wales had already had to rely on 100,000 FFP3 masks from England, of which only 10,000 remained [INQ000551495_003]. Supplies were well below those available to the other UK nations per capita, as the table below demonstrates.

Table 1: FFP3 mask to population ratio

UK Nation	Number of in date FFP3 masks 12 March 2020	Population in mid-2020 (ONS)	Mask to population ratio
England	1,500,000	56,550,000	1:48
Scotland	113,000	5,466,000	1:38
Wales	10,000	3,170,000	1:317
Northern Ireland	99,000	1,896,000	1:19

Sources: INQ000551495 and ONS population statistics in mid-2020.

21) As shown above, Wales' stockpile of FFP3 masks was woefully inadequate and well short of supplies in other UK nations. To put that in context, despite having almost double the population of Northern Ireland, Wales had only 10% of their supply of FFP3 masks.

Addressing the deficiencies: Just-In-Time contracts and re-testing of FFP3 masks

22) It remains unclear if, when and how the Welsh Government addressed deficiencies. An emergency 'Just-In-Time' order had been placed by 18 March 2020 [INQ000505360], but as the Inquiry has heard in oral evidence, 'Just-In-Time' contracts did not deliver. The Audit Wales report of April 2021 reported that the 'Just-In-Time' contracts failed. Audit Wales stated that, *"due to a lack of supply in the global market, these 'just-in-time' contracts did not deliver as fully as expected, with none of the FFP3 respirators being received*" [INQ000214235_0013 at §1.3].

23) The CBFJ Cymru invites the Inquiry to approach the evidence that the Welsh Government ensured swift re-testing of out-of-date FFP3 masks with caution. Mr Brace said that, as far as he was aware, there was no problem with out-of-date stock – it had been re-tested (it was simply that it had not been given a label to confirm it had been re-tested, thereby giving rise to concerns among the trade unions that stock was out of date). His evidence suggested, in other words, there was no problem with out-of-date stock at all [Brace; 6/182/19-6/183/5 and 6/183/20-6/183/24]. Similarly, Jonathan Irvine, director of procurement at NWSSP, gave evidence that the FFP3 masks were re-tested and in circulation by 25 March 2020 [Irvine; 14/114/18]. However, Welsh Government records show that as of 18 March 2020, the FFP3 stock remained out of

date, with re-testing achievable within 4 to 16 weeks to re-test, depending on the age of the stock [INQ000504943].

24) Regardless of the exact time frames of re-testing, the CBFJ Cymru is concerned about a number of aspects of the re-resting. First, it seems clear the body in Wales responsible for re-testing, Surgical Material Testing Laboratory ("SMTL"), did not have the expertise or relevant equipment needed to conduct re-testing. This is acknowledged in its own report ("Test Report, 27 February 2020"[2]) which records that aspects of the testing had to be subcontracted.[3] Secondly, the face-fit testing SMTL undertook returned a high failure rate: it was a "fail" in half the cases, owing to face size, shape etc. - largely because they did not fit women (Test Report, 27 February 2020; Table 4 p.9; Discussion p.13 at §8.1). Given 70% of the health and social workforce are women, the figures are highly troubling. Plainly, if the masks do not fit, they offer no protection to the health care workers or patients they are designed to protect. Thirdly, the CBFJ Cymru notes the 3M Respirator timeline analysis report makes reference to the SMTL report and claims it "*demonstrates that the products are safe to use*" (INQ000269725 entry for 28 February 2020). The CBFJ Cyrmu questions how this can be the case given, as the report itself acknowledged, such a high proportion failed the fit test.

Reasons for deficiencies in Wales' stockpile

25) It must be stressed that the deficiencies cannot be attributed to a UK-wide PIPP strategy which underestimated the demand in the event of a pandemic: the Wales stockpile did not contain that which it was supposed to contain. And it was the responsibility of the Welsh Government, not Westminster, nor the NWSSP, to maintain adequate and in-date stock.

26) As to why stocks were out-of-date, Mr Irvine could not assist when he gave evidence at the Inquiry. He made clear that the Welsh Government were aware of the problems: there were regular stock reviews carried out with Welsh Government officials. "*I'm not trying to be evasive*", he said, "*that would have been a decision that Welsh Government would have had to have taken and it would have been a matter for them to have*

[2] This document is Appendix B referenced in INQ000269725_0001 entry 28.02.2020 re. Welsh colleagues

[3] The CBFJ Cymru observes that even today, SMTL's current UKAS certificate demonstrates it does not have the accreditation to test FFP3 masks; if it were the case it was also not accredited in 2020, the group questions why it was instructed to conduct the re-testing on behalf of NWSSP in the first place and notes the obvious risk to healthcare workers (and patients) arising from such a decision.

answered" [Irvine; 14/111/7-11]. The CBFJ Cymru observes that the Welsh Government have not answered that question. Notwithstanding witness statements totalling hundreds of pages, and notwithstanding thousands of exhibits, the answer to this very simple question remains elusive.

Conclusion

27) The CBFJ Cymru urges the Inquiry to view with caution the assertions which appear (verbatim) in several statements prepared by those working for the Welsh Government that the stockpile was "*crucial during the first four months of the Covid-19 response and gained time to enable the NHS Wales Shared Services Partnership to successfully secure ongoing PPE supplies*" [Slade; INQ000506956_0042 at §174; Gething INQ000536418_0024 at §104]. Talk of "success" is inappropriate. Supplies were not secured. Members of the group experienced firsthand the devastating effects of shortages of PPE and inadequate PPE. The Chair will have to make recommendations following this Inquiry. And yet, in the absence of any recognition and explanation of the failure of the Welsh Government to maintain adequate stockpiles, the opportunity for the Welsh Government to learn lessons for the future is necessarily limited.

PPE AND EQUIPMENT IN HOSPITALS

Introduction

28) After some introductory remarks, this section on PPE and equipment in hospitals covers:
    a) Wales "never ran out of PPE": a misleading claim
    b) Extent of shortages of PPE and equipment in hospitals
    c) Reasons for shortages/inadequacies in type of PPE in hospitals
        i) Distribution problems
    d) Conclusion

29) The Inquiry will consider principal issues in the distribution of PPE [**LoI 4 §16**].

30) The Inquiry will be aware that many CBFJ Cymru members suffered bereavement following a hospital or care home acquired infection. The CBFJ Cymru believe that the lack of adequate PPE within Welsh hospitals and care homes was a major cause of the high levels of infection and deaths experienced. Such nosocomial transmission is

one of the principal symptoms of the failure to distribute PPE and equipment to hospitals.

Wales "never ran out of PPE": a misleading claim

31) The Inquiry has been told repeatedly by the Welsh Government and its politicians that, on a national level, PPE stocks in Wales never ran out [e.g. witness statement of Mark Drakeford INQ000528293_0007]. Alan Brace, Andrew Slade and Jonathan Irvine all repeated that Wales "never ran out" of PPE when they gave evidence to the Inquiry.

32) The claim that Wales "never ran out" of PPE has the potential to be a highly misleading claim. This is because those monitoring and distributing the stock – NWSSP - were also the ones managing requests for PPE, determining what proportion of any request would be supplied. Mr Irvine may not have liked the term "demand management" when asked in evidence whether Wales engaged in "demand management", but that is the very process he described:

> *"I wouldn't term it in that way [demand management]. Certainly in the initial two, three weeks, maybe four weeks…most of March…We were dealing with a finite amount of stock that was held in the PIPP stockpile, with no, certainly up to the third week of March, I would argue, no clear line of sight as to how that was going to be replenished or if it was going to be replenished. Bearing that in mind and hearing in mind what'd I'd just previously said about potential…almost panic to get product into the hospitals, we had to make sure that all PPE stockpile was available to all health boards and trusts across Wales. We couldn't have a position where one health board came in and took 60-70% of the stock leaving others without anything. So in this respect we had to make sure there were sufficient quantities for everybody. So we had to make a determination"* [Irvine; 14/130/20-14/131/17].

33) To put it another way: if Wales did not run out, it is not because demand was met, it was precisely because demand was not met, NWSSP allocating in order to ensure its stockpiles did not run out, rather than allocating to meet need.

34) In any event, even if Wales did not run out at a national level, the more relevant issue is why healthcare workers and patients in hospitals did not have the necessary PPE.

Extent of shortages of PPE and equipment in hospitals

35) Just over five years ago, Wales reported one of its first deaths from a hospital acquired covid infection. Douglas Miles was admitted to the Holywell Community Hospital in Denbigh for an operation. But he caught covid whilst in hospital and, tragically, on 29 March 2020, passed away. His daughter, Sylvia Parry, said "there was no PPE at the time and my father was just a sitting duck in the hospital". She observed undertakers attending in full hazmat suits, whilst healthcare workers, reliant on supplies from Local Health Boards, had nothing. It would prove to be one of the first of many deaths in Wales from nosocomial covid infection. And it is a story to which many in the group relate:

a) Ann-Marie Richards (from whom the Inquiry heard in the Module 5 impact video). Her husband went into hospital in December 2020 to be treated for sepsis. He caught covid in his ward and tragically never recovered. When Hywel Dda Health Board reviewed his case, they found that on Mr Richard's ward, 25 patients had tested positive for covid, and 25 staff members had tested positive for covid. The Board simply told Mrs Richards, opaquely, that "exposure to multiple hospital environments would have made Mr Richards more vulnerable to hospital acquired infections".

b) Sam Smith-Higgins, co-leader of the CBFJ Cymru group. She told the Inquiry in her oral evidence in Module 4 [2/115/21-117/22] about her fears for her 73-year-old father, who was admitted to hospital in early January 2021 for cancer related treatment and was immune suppressed and vulnerable. He was not permitted access to a high efficiency particulate arresting ("HEPA") filter (even though they are low cost and portable, and even though Ms Smith-Higgins offered to source one herself). Nor was he ever offered a mask. Tragically, just three weeks after being admitted to hospital, he died from a Covid-19 infection acquired in hospital.

c) Anna-Louise Marsh-Rees, co-leader of the CBFJ Cymru group. Her father went into hospital for a gall-bladder operation. On his non-covid ward, 21 patients had covid. Tragically, of those, 12 - including Anna-Louise's father - passed away from Covid-19.

36) There are many more such examples. The experience of many in Wave 1 was that they would attend hospital to find healthcare workers "with zero to minimal PPE". In Wave 2, members saw healthcare workers generally equipped with surgical masks, gloves and aprons, but no FFP3. By that stage, of course, the nature of aerosol

transmission of Covid-19 was known, and yet healthcare workers were under-protected. The result was that patients caught covid whilst in hospital.

37) It was well known in communities across Wales, particularly as the pandemic went on, that there was a high risk of nosocomial transmission upon admission to hospital. Families felt a grim inevitability that, if admitted to hospital during the pandemic, their loved one would contract covid. Their fears were well founded: data from Public Health Wales ("PHW") showed that, as of 24 February 2021, of the 1,002 patients in Welsh hospitals testing positive for covid, 529 of these (53%) were classified as "hospital onset" cases [INQ000227307_0002]. The situation has not improved: PHW data as of 09 February 2025 shows some 83% of inpatient Covid-19 cases in Wales were the result of hospital-acquired infection.

38) Examples from healthcare workers are consistent with the accounts from members of the group. We note by way of illustrative example only:
    a) a consultant in Wales told the British Medical Association: "At the start, despite knowing of the virus spread, no PPE was provided. Not even masks let alone thinking of level 2 PPE for aerosol generating procedures. This was when many of my colleagues and I became ill."
    b) a GP in Bangor spoke of "rationing" out their PPE, having to use it only on patients who were strongly suspected of having Covid-19 through symptoms such as a cough or fever. Staff were also having to wear goggles procured from a DIY shop.
    c) Gareth Davies, a nurse working in Llandough Hospital, warned his family he was having to work in a paper mask, without PPE. He contracted coronavirus and passed away in April 2020.

39) Examples of re-use of PPE tell a similar story of shortage. As Adam Morgan from Wales TUC observed in his witness statement in Module 2B [1NQ000400723_0024]:

> *86. The Welsh Government did not follow the UK guidance to reuse PPE. Nevertheless a GMB representative reported that staff in Welsh hospitals were being encouraged to share PPE that should have been single use, including versa-flow hoods that workers would breathe through for entire shifts. When staff complained, they were told that they had no choice. Staff were alarmed by the risk of infection created by reusing colleagues' hoods, and the suggestion was only dropped after significant resistance from Unite. I was told*

by CSP members that the advice regarding appropriate PPE appeared to be based on availability rather than the level of protection afforded [Exhibit AM/58 - INO000339547].

40) The suggestion by PHW, in November 2020, that "deeply ingrained and cultural" staff behaviours was responsible for the high rate of transmission in hospitals was, to say the least, surprising [INQ000396261_0001] (one Health Board reported the infection rate was 24% among staff, as compared to 1% in the community). No doubt, the many patients and healthcare workers who experienced the shortages might suggest a more obvious reason for the spread of infection: a lack of PPE.

Poor ventilation in Welsh hospitals

41) PPE shortages were exacerbated by inadequate ventilation in Welsh hospitals. The CBFJ Cymru reminds the Inquiry of the evidence of Dr Shin in Module 3 that there was insufficient consideration given to ventilation beyond the opening of windows. Dr Shin in his oral evidence recommended common-sense alternatives to installing new ventilation, namely UV filtration system and HEPA filters [Shin; 08/172/3–08/174/4] which were low cost and portable. Baroness Morgan flippantly joked that a HEPA filter had been her most disappointing Christmas present [Morgan; 35/195/6-8]. On the contrary, for CBFJ Cymru, HEPA filters are a valuable piece of equipment which could have reduced nosocomial transmission rates and potentially saved lives. The Inquiry will also be aware of the evidence in Module 2B of the Chief Nursing Officer for Wales, Professor Jean White, who explained that the hospital estate in Wales was old, and would not have therefore been well ventilated [White; 6/114/20-25].

Reasons for shortages/inadequacies in type of PPE in hospitals

42) Whether as a result of "demand management" by NWSSP or not, even if Wales did not run out of PPE, that is of little comfort to those who experienced shortages at a local level. What good is a long-sleeved gown and FFP3 mask in a warehouse in Denbigh, when it is needed at the local hospital, where covid is spreading through the ward, among staff and patients alike? Or, as Professor Manners-Bell put it:

> "*not getting [goods or] PPE to the right place means a critical supply chain failure. You [might as well not] have bothered to have had those goods in the*

first place if you're not able to get them to where they're needed at the right time, to the right people." [Manners-Bell; 5/12/22].

43) Failure of planning and preparation resulted in a Welsh stockpile that was woefully lacking in Respiratory Protective Equipment such as FFP3, and faced with no means of procuring sufficient stock, this equipment was rationed to ICU settings and AGP procedures by means of the IPC guidance, leaving patients and staff outside of these settings more vulnerable to infection. The group considers this to be one of the main underlying reasons for the shortages – and is explained in further detail above (Pandemic Stockpile) and also below (IPC Guidance and FFP3 masks).

44) A further reason for shortages is distribution of PPE.

Distribution problems

45) Mr Slade (Welsh Government) suggested problems in supply and distribution related to a lack of information about (i) what was needed and where and (ii) what stocks were held at a local level. There was, apparently, no system of knowing how much stock hospitals had – they were starting from scratch. So, problems arose because there were inadequate flows of information and intelligence.

46) Mr Brace (Welsh Government) suggested confusion in distribution was caused by IPC guidance: "*the change in guidance…caused a lot of tension at the direct service end around what PPE was required and did we have the right mix of PPE*" [Brace; 6/202/19-24]. He suggested that guidance led to tensions in staff understanding what was required and therefore supplied: his claim was unsubstantiated, but in any event was a red herring, given (as the Inquiry has heard in previous modules) changes in IPC guidance did not substantially alter PPE e.g. mask wearing.

47) And like Mr Slade, Mr Brace suggested there was plenty of stock, but there were problems with information about that stock. He said: "*there weren't any hospitals without stock…but there clearly was coordination issues at the hospital end about what stock was held and where, and how to distribute it as quickly as possible across the various sites and hospitals and hospitals within the hospital*". [Brace; 6/189/1]. He described it as a "*disconnect*" between the Local Health Board's understanding of available stock, and NWSSP's understanding that they had "*pushed out enough stock to the NHS*" [Brace; 6/189/8-6/190/4]. He later seemed to suggest it was simply about

speed: it went to a distribution point [Brace; 6/204/5-14], but it was about how quickly it could get to the wards: "*every hospital has got a central receipt and distribution point that then distributes to wards. So there would have been stock in receipt and distribution points and I guess the challenge was how was that – how quickly…*" [Brace; 6/204/9-13].

48) And finally, Mr Brace suggested problems in distribution were because NWSSP operated a "push" system, rather than a demand system – which was how they normally operated with the local Health Boards [Brace; 6/205/4-8]. He did not elaborate further.

49) Such explanations raise more questions than answers. NWSSP had been supplying PPE to Health Boards and hospitals for the best part of a decade when the pandemic started (since 2011). Distribution paths and delivery points must have been well established. Why had not even the most basic stock management system been put in place? Why did NWSSP use a "push" system, when it had not done so previously? And if it is correct that there was plenty of stock floating around the NHS estate in Wales, why did the problem go unattended or unsolved, once it was realised (certainly by 30 April 2020, when the military logistics report was produced [INQ000470703] that this was a serious problem.

50) Whilst the Welsh Government felt, as Mr Brace said in evidence, "confident and assured" they had a grip on the situation in April/May 2020, this was evidently not the case. Healthcare workers and members of the group alike witnessed shortages throughout 2020 and into 2021:

    a) In April 2020, an RCN survey of nurses in Wales reported on the sufficiency of particular PPE items: only 52% had sufficient eye protection; 46% - Type IIR masks, 63% - FFP3 respirators, 57% long sleeved gowns.
    b) In February 2021, a BMA survey of doctors in Wales reported that just 37% had sufficient PPE for non-aerosol generating procedures, whilst 44% said that it was not adequate. As to PPE items that would help doctors feel safe, 88% identified FFP3 masks and 45% identified long-sleeved disposable gowns [INQ000214235 - Procuring and Supplying PPE for the covid-19 pandemic, Audit Wales 2021].

51) The reasons that essential PPE and equipment failed to reach the frontline are far from clear. The Inquiry heard from Welsh Government witnesses and NWSSP. They, by

inference, pointed the finger to failings at a more local level. That may be correct, incorrect or partially correct. The position is not known. Significantly, no evidence was called from those operating at a more local level, such as the Local Health Boards, who may have been able to provide the Inquiry with valuable insights into whether and why there were distribution and logistics problem at a Local Health Board or hospital level.

Conclusion

52) Notwithstanding the repeated claims that the PPE stocks distributed by the NWSSP never ran out, the reality was that they did; or at least stock did not reach those who needed it. Plainly healthcare workers are among those who needed it most.

53) Many of the group question why the Welsh Government was so slow to react to the issue. Many of them question why the staff and patients and residents in hospitals and care homes were unable to take the precautions necessary to curb the spread of the virus. They believe that the reason why Wales has the highest rate of nosocomial deaths must have been due to the lack of any PPE, or appropriate PPE, resulting in mass cluster outbreaks in wards and care homes across Wales.

54) Given that there was such limited exploration as to why those that needed PPE did not have it, the concern of the CBFJ Cymru is that there remains a significant gap in understanding this key aspect of the module. And, again, without an understanding of the problem, there can be no confidence or assurance that the Welsh Government have learned any lessons for the future.

PPE AND EQUIPMENT IN CARE HOMES

Introduction

55) After some introductory remarks, this section on PPE and equipment in care homes covers:

a) Wales "never ran out of PPE" in the social care sector: a misleading claim

b) Extent of shortages of PPE and equipment in care homes
c) Reasons for shortages/inadequacies in type of PPE in care homes
    i) Delays in recognising the PPE needs of care homes
    ii) Distribution problems
d) Other concerns about PPE and equipment in care homes
    i) Shortcomings in the level of protection offered in care homes
    ii) IPC guidance for care home workers on the use of PPE was inadequate

56) The Inquiry will be considering the extent to which systems for distribution and procurement of PPE met the needs of the care sector [**LoI 4 §18**].

57) The supply of PPE to care homes is a particular concern for the members of the CBFJ Cymru, a large number of whom lost loved ones in care homes during the pandemic.

Wales "never ran out of PPE" in the social care sector: a misleading claim

58) Here, again, the narrative from the Welsh Government is that, like the healthcare system, the social care system never ran out of stock. For example, Mr Brace said that the only time he was aware of a care home running out of PPE was a false alarm:

> *"a call came through to the ministerial team that one of the care homes in one of the local authorities in Wales had run out of PPE, and there was none available. I contacted Mark Roscow in Shared Services who said that's very unusual because the joint equipment store has been replenished. He sent a van there and actually the joint equipment store was complete with stock, but there were clearly communication or distribution issues just between that care home, the local authority, and the joint equipment store"* [6/201/9-21].

59) The basis upon which this is said has not been explained or explored. To the extent that it relies on stock data from the Welsh Government/NWSSP that Wales never ran out of stock at a national level, such a claim is potentially misleading: demand management ensured that it never ran out, irrespective of demand and/or need (see above in respect of hospitals).

In any event, the claim is misleading. There is an overwhelming amount of evidence that shows that those in care homes did not have the PPE, and type of PPE, they

needed. And those who experienced first-hand the shortages, and the use of inappropriate PPE, will no doubt find it hard to understand why the PPE Supply and Distribution Cell for the Welsh Government, headed by Mr Brace, was apparently so misinformed. The failures to supply care homes with adequate and appropriate PPE and equipment are widely reported; they cannot be denied.

Extent of shortages of PPE and equipment in care homes

60) Helena Herklots, the Older People's Commissioner for Wales, wrote to the Welsh Government on 14 April 2020, expressing concern about access to PPE in care homes. She explained the context for her letter when she gave evidence to the Inquiry on 28 February 2024 in Module 2B:

> "*So at that point I was having some dialogue with care home owners, I was hearing from care home staff and also family and friends of people living in care homes. What I was hearing in relation to PPE is that the supply was inconsistent. So some homes had the PPE that they needed, but others were really struggling to get it, trying to purchase it directly themselves, or struggling to secure it from the distribution mechanisms that were then in place… So it was causing quite a lot of homes a lot of anxiety and stress about not having the PPE that they needed. And I think also they were concerned about, if they did have it, whether that supply would continue consistently for the time that they needed it.*" [Herklots; 2/124/5]

61) Dr Chris Llewelyn, Chief Executive Officer of the Welsh Local Government Association (WLGA), reported similar issues among local authorities (the care sector):

> *"While it was reported that Shared Services' did not run out of stock for any item of PPE during the pandemic (Exhibit CL/101 - INQ000473214: 210315 AW PPE Report Working Draft), which may have been true for NHS bodies, there are accounts of local authorities being unable to obtain supply of requested items through Shared Services at points throughout the pandemic"* [INQ000518355_0020 at §46].

62) And furthermore, Dr Chris Llewelyn observed that even if NWSSP made available the quantity of stock (such that "demand appeared to be met") this was not necessarily the correct stock:

"47. The WLGA is also aware of circumstances where demand for PPE was met 'on paper' however in practice the supplies could not be utilised by care professionals. For example, throughout August and September 2020 the overall quantity of nitrile examination gloves available to the care sector was sufficient, but they were not available in sizes that could be used by care professionals…

48. This issue was not exclusive to gloves and issues were experienced with other PPE equipment. For example, aprons issued as 'one size fits all' did not provide significant coverage to some care workers and there were concerns that there was a risk of workwear being contaminated during personal care interventions. With regards to masks, some workers experienced a reaction to certain brand masks which potentially contained latex, while other brand masks did not mould around the nose appropriately resulting in staff constantly touching them to re-adjust. These products were eventually withdrawn from use, but at a point in time would have been considered as meeting PPE demand". [INQ000518355_0020-21 at §§47-48]

63) Statements from Ms Herklots and Dr Llewelyn are consistent with the experiences of the members of the group itself. Catherine Griffiths' tragic experience epitomises this. Her father contracted covid in his care home in Aberystwyth. She describes the last time she saw him:

"On 16th November 2020, I was invited to the home to say 'goodbye' to Dad. I wanted to go in and be by his side and to hold and comfort Dad; my brother urged me not to. The level of PPE in the home was abysmal; we could see the nurse wearing just an apron and a flimsy surgical mask. I was forced to say goodbye to my father whilst standing in the icy rain, outside his window." [INQ000474759_0020 at §69[4]]

Reasons for shortages/inadequacies in the type of PPE in care homes

64) The claim that Wales never ran out of PPE in the social care sector (evidently incorrect) is in any event an irrelevant one. To repeat the evidence of Professor Manners Bell: *not getting [goods or] PPE to the right place means a critical supply chain failure. You*

[4] Statement disclosed in Module 6

[might as well not] have bothered to have had those goods in the first place if you're not able to get them to where they're needed at the right time, to the right people.". [Manners-Bell; 5/12/22]. What good is a mask in a warehouse in Bridgend, when it is needed at the local care home, where covid is spreading through the home, among staff and patients alike? The more relevant question is why care homes experienced such shortages and what were the nature of the shortages. The CBFJ Cymru note the following reasons for shortages from the evidence available:

a) Delays in recognising the PPE needs of care homes
b) There were distribution problems

Delays in recognising the PPE needs of care homes

65) There was a delay in providing PPE to care homes. As Mr Slade told the Inquiry, the likely need to deliver PPE to social care settings was recognised as early as 18 February 2020 [INQ000470674]. Yet it was not until 19 March 2020 that the remit of the NWSSP was extended to procure and supply care homes. Those operating at a local authority level felt that the Welsh Government failed to recognise the needs of social care settings, as it prioritised supply of PPE for the NHS [INQ000518355_0009 at §19 and §21].

66) During the first few months of Covid, and notwithstanding the expanded role of the NWSSP on 19 March 2020, councils were seeking supplies of PPE from the NHS, but such supplies were dependent on a positive case being identified, and in any event the nature and timing of provision from NHS stock was unknown. Local authorities had to forecast demand, place their own orders and chase supply [INQ000518355_0010 at §§20-22]. By May 2020 only two thirds had their PPE needs meet by NWSSP. It was not until much later – September 2020 – that a Service Level Agreement between the NWSSP and the WLGA was reached [INQ000518355_0010 at §§29-30; 43], an agreement only formalised in a letter to social care providers on 12 October 2020. By that stage, of course, Wave 2 of the pandemic was already underway.

67) Mr Slade did not accept care homes had been overlooked whilst the NHS was prioritised. Nor did he accept that the Welsh Government could and should have acted more quickly to assist care homes. But the recognition by both himself and Mr Brace that, in a future pandemic, NWSSP should or would provide PPE immediately for the care sector tells you that the response to supply PPE to care homes was too slow.

68) The delay is epitomised by the reaction of the Welsh Government to the request from Ms Herklots for an Action Plan to address the problem of care homes in Wales. Ms Herklots met Julie Morgan, Deputy Minister for Health and Social Services, on 9 April 2020, to raise concerns about the situation for staff and residents in care homes, and the anxieties felt by their loved ones. By that stage, as Ms Herklots noted, Ms Morgan had announced that there had been confirmed or suspected cases in nearly a third of Wales' care homes. Further to the meeting, on 14 April 2020, Ms Herklots wrote to the Ms Morgan and invited her to make an Action Plan [INQ000184935]. She explained the rationale for the Plan when giving evidence to the Inquiry in Module 2B:

> *"I struggling to see how the work to help older people living in care homes and those working in them, how that was being led and co-ordinated… and if I was struggling to see it, it was going to be even more difficult for people in care homes and families and friends to actually see what was happening....there needed to be an urgency and focus, that I couldn't see at the time*." [Herklots; 2/130/3].

69) Ms Herklots asked Ms Morgan to lead and set out an action plan to drive faster progress, faster action to protect older people. By reply on 21 April 2020 [INQ000184940] Ms Morgan said she was:

> "*…not convinced that an additional plan of action over and above those arrangements…will add value here but we will certainly report on progress via the Social care Sub-group."*

70) Ms Herklots was, unsurprisingly, angered that Ms Morgan was suggesting that working on an action plan "*would add no value, at a time when people were dying in care homes, where families were distraught."* [Herklots; 2/131/2]. It took a report published on 21 June 2020, *"Care Home Voices: A snapshot of life in care homes in Wales during Covid-19"* [INQ000181725] to jolt the Welsh Government into action. An Action Plan was eventually published on 30 July 2020, over three and a half months after the Welsh Government had been asked to prepare a plan. The CBFJ Cymru is concerned that valuable time was lost to protect this most vulnerable of populations in Wales.

Distribution problems

71) Another reason for lack of PPE and appropriate PPE in care homes appears to have arisen from distribution problems. We know that NWSSP supplied stock from its national stores to Local Authority Joint Equipment Stores, for onward distribution to the care sector by local authorities. We also know that this process did not work as it should have.

72) Mr Irvine said there was "more than enough PPE in the joint equipment stores…but the Joint Equipment Stores or local authorities more generally weren't necessarily aware of what was actually there" [Irvine; 14/154/16].

73) Mr Irvine's suggestion is hard to understand: it implies local authorities and care homes, desperately in need of PPE, could have had more than they needed, if only they'd checked their local joint equipment store. If that is right, then the obvious question arises: why was the matter not be resolved easily, by simple and better communication between NWSSP, local authorities, and the end user?

74) Mr Irvine's suggestion is also hard to understand given Stock Watch, the inventory management system designed to enable NWSSP to understand what was needed and where, was unfit for purpose (and was recognised by Mr Irvine as such). The system relied on email updates from local authorities, or, from November 2020, direct input from local authorities themselves. Whichever the method, NWSSP were not able to "understand that we were fulfilling their full requirements" [Irvine; 14/153/22] and there were "gaps in how much stock [those] areas actually required" [Irvine; 14/135/25]. If the Inquiry were to accept that the joint equipment stores were full to overflowing, that would have been by luck, rather than by design. It is a question of "if": the Inquiry has not heard from the local authorities and care homes providers; it might be that they would provide some useful information on how or why the system failed from their perspective. They may even have a narrative to counter the implicit suggestion that failures lay with them, at a local level.

75) The Welsh Government had little to offer by way of their own insights into problems in care homes. Mr Brace said he "*would not want to comment about every instance of where that was felt in social care*" [Brace; 6/203/18]. Indeed, he did not comment on any instance – beyond saying there was one false alarm. Nor could Mr Irvine help – he said "*the more important issue*" was to understand the responsibilities of NWSSP and "*where they started and where they ended*" [Irvine; 14/155/17-20] – i.e. it was not the responsibility of NWSSP. Such siloed thinking perhaps reveals more than Mr Irvine

intended. It certainly assists the CBFJ Cymru in understanding why problems, once identified, would not be resolved. Unlike Mr Irvine, for the members of CBFJ Cymru, the most important thing was not where NWSSP's role started and ended. It was why healthcare workers and residents in care homes were so overlooked and poorly serviced when it came to PPE and essential healthcare equipment, and why their loved ones died because a lack of proper protection.

76) Finally, there is a shortcoming underpinning these distribution concerns, which suggests distribution to care homes in Wales was always going to be problematic. As the former First Minister, Mr Drakeford, admitted in oral evidence during Module 2B [Drakeford; 11/211/15], there was no single register of the location of every care home in Wales. Having regard to this position, the CBFJ Cymru suggests that it will be important for the Inquiry to understand how the Welsh Government was able to ensure the supply of necessary PPE to care homes, when the extent of their existence and operation was not known.

Other concerns about PPE and equipment in care homes

77) The CBFJ Cymru note the following additional concerns in relation to PPE and equipment in care homes in Wales:

a) Shortcomings in the level of protection offered in care homes
b) IPC guidance for care home workers on the use of PPE was inadequate

Shortcomings in the level of protection offered in care homes

78) There were shortcomings in the level of PPE protection in care homes. The NWSSP packs prepared and distributed to local authorities for onward distribution to care homes contained a fluid resistant surgical mask, apron, gloves and eye protection [INQ000470675]. These were the items that were subject to the SLA formalised in September 2020 and about which care homes were formally notified on 12 October 2020. These items continued to comprise the stock made available to care homes via their local authorities throughout the pandemic (as shown by data from Stock Watch, the electronic stock management system) [INQ000436116]. Yet, as set out below, FFP3 masks - absent in the packs - were essential in preventing the spread of aerosol transmission.

IPC guidance for care home workers on the use of PPE was inadequate

79) The IPC guidance for care home workers on the use of PPE was inadequate. PPE guidance for care homes was based on UK/national level guidance. It therefore suffered from the same failings as nationally agreed IPC guidance (further details in the section below).

80) The effect of the failure to recognise the asymptomatic nature of the virus, and its airborne transmission, was particularly marked in care homes. The Minister for Health and Social Care, Vaughan Gething, announced on 16 March 2020 that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. A letter to social care providers on 18 March 2020 following Mr Gething's announcement confirmed (i) PPE was for those directly caring for confirmed or suspected cases, and (ii) that higher level of PPE was "unlikely to be needed" in a social care setting – such equipment only being needed by those undertaking AGPs [INQ000470681].

81) Further, PPE guidance for social care settings was said to be adapted by Public Health Wales to a social care setting [INQ000506956_0068 at §287]. However, in the opinion of those working in the sector (who were already disadvantaged by the lower levels of training in PPE use as compared to NHS staff) the guidance was poorly adapted. Dr Chris Llewelyn, Chief Executive of the WLGA, summarised the problem as follows:

> "*Guidance, where available, was predicated on NHS applications and did not easily translate into non-hospital care settings...it was also not clear about the specific application of PPE required in different situations*" [INQ000518355_009 §19; §34].

82) The lack of clarity had a knock-on effect on supply: the guidance left room for interpretation and as such affected usage, and in turn hampered the ability to accurately predict demand for PPE in the care sector [Dr Chris Llewelyn, INQ000518355_017 §36].

83) For completion, we note that the most recent PHW IPC guidance for Acute Respiratory Infections ("ARIs") in Wales (2024-2025)[5] recommends that social care staff use "*FRSM (type IIR) when working in respiratory care pathways and when clinically caring*

[5] Infection Prevention and Control Measures for Acute Respiratory Infections (ARI) for Health and social Care Settings – WALES 2024 Version 3.0a.

for suspected/confirmed COVID-19 and Flu patients" (p.8/17) and only recommends FFP3 masks "*if an unacceptable risk of transmission remains following the hierarchy of controls*" (p.15/17). It is not known how those in care homes – a "high risk setting" because they cannot mitigate risk with a hierarchy of controls (p.6/17) - are expected to conclude there is "unacceptable risk following the hierarchy of control", such that FFP3s are required. It seems therefore that current guidance for care homes does little to correct deficiencies in earlier guidance.

VENTILATORS, OXYGEN AND CPAPS

84) The concerns of CBFJ Cymru in this module have not been confined to PPE but extend to key equipment such as ventilators and CPAPs.

85) The Inquiry heard much evidence as to the procurement activities for ventilators by the UK government. Of course, it is recognised that procurement of these significant pieces of equipment took place on a UK-wide basis. Whilst it is clear therefore that Wales benefited from such UK-wide procurement, a more detailed picture of whether Wales had sufficient ventilators (and how that was measured) is less clear. Certainly, its members experienced shortcoming and failures in access to ventilators and other key equipment, as the examples below show:

    a) Marita Edwards was admitted to hospital in February 2020 for a routine operation. She was otherwise fit and healthy. But she caught covid whilst in hospital and tragically she passed away. Her son, Stuart Loud, questions why she was not put on a ventilator, and whether this decision was a result of a lack of resources, which meant staff had to hedge their bets on whether younger people might be infected and would need that equipment.
    b) Paul Jones (who has provided a witness statement to the Inquiry) and his wife Karen lost their 25-year-old daughter, Lauren, in December 2020. Staff delayed getting her onto a ventilator until her oxygen saturation level was at just 10%, almost 24 hours after being notified that she would need to go on a ventilator. He wonders why a ventilator was not made available sooner.

86) The only witness to be called to give evidence on key equipment such as ventilators and CPAPs in Wales was Richard Davis, the lead government official with the Critical Equipment Requirement Engineering Team (CERET). He gave evidence to the Inquiry for some 30 minutes. He could not assist with issues of access to ventilators and CPAPs, save to say that CERET was directed away from involvement in

making/procuring ventilators and CPAPs – they were simply told what to do by NWSSP. He did say, adopting a now familiar line, that Wales "*never ran out of vital, critical equipment*" [Davis; 14/169/22]. The CBFJ Cymru invites the Inquiry to treat such claims with caution. There has been no scrutiny of such claims, and they sit at odds with the experience of the group's members.

INFECTION PREVENTION AND CONTROL ("IPC") GUIDANCE ON FFP3 MASKS

Introduction

87) After some introductory remarks, this section on IPC Guidance and FFP3 masks, this section sets out:
   a) Evidence that there is serious doubt that the IPC guidance was correct
   b) Evidence that that IPC guidance was driven by resource/constraints in supply
   c) Conclusion

88) The Inquiry will consider the operation and effectiveness of guidance in relation to key medical equipment and supplies [**"Outline of Scope" §3; LoI §§4-10: "Structures, systems and processes"**]. Although the primary focus of the Inquiry here may be guidance in respect of procurement, the CBFJ Cymru nevertheless is concerned to highlight the significant role played by IPC guidance in respect of PPE procurement.

89) The IPC guidance was a product of the UK IPC Cell, which brought together IPC leads from NHS and public health bodies across the four nations, including Wales. It set out what level of PPE protection was needed, and by whom, in different clinical scenarios. Thus, IPC guidance was critical in shaping the decision making for the procurement and supply of PPE [w/s Dr Eleri Davis, Public Health Wales, INQ000557344 at §42].

90) The nature of the IPC guidance in so far as relevant to PPE procurement is summarised in the witness statement of Jonathan Marron [INQ000528391_0063 to _0068]. In short, the IPC guidance was that from 13 March 2020, FFP3 masks were recommended only for treatment in ICU, or for Aerosol Generating Procedures ("AGPs"). This guidance was said to be "*based on the reasonable assumption that the transmission characteristics of Covid-19 were similar to those of the 2003 SARS-CoV outbreak, mainly transmitted through respiratory droplets generating by coughing and sneezing, and through contact with contaminated surfaces*" [w/s of Jonathan Marron INQ000528391_0066 §245; IPC guidance at INQ000325350]. This "reasonable

assumption" requires scrutiny, given the large body of evidence pointing to transmission via aerosol (in addition to droplets).

91) Against this background, CBFJ Cymru makes two main submissions:
    a) There is serious doubt that the IPC guidance was correct
    b) There are serious concerns that IPC guidance was driven by resource/constraints in supply

Evidence that there is serious doubt that the IPC guidance was correct

92) First, there must be serious doubt as to whether the IPC guidance was correct to limit the use of FFP3s to ICU/AGP scenarios. This is not a question of having the benefit of hindsight. This is a question of failing to fully acknowledge the risk at the time the IPC guidance was issued that Covid was spread via aerosol transmission.

93) The CBFJ Cymru has considered the closing submissions of the British Medical Association (Module 1 §§20-25; Module 2 §§37-61 and Module 3 §§37-48) and invites the Inquiry to consider them afresh reporting on Module 5, given the cross-cutting nature of the PPE issue. Suffice here to say that Professor Van Tam's understanding, as at January 2020, was that "*the historical HSE statutory position is that maximum level RPE is required*" [INQ000151353]. Such a position was consistent with advice received in late March/early April from a coronavirus expert in Belgium to medical officers in the UK: "*It must also be understood that aerosol transmission means workers need FFP2 for effective protection. The surgical masks are not protective enough, but they do have a place*" [INQ000454404]. By that stage, experts such as Professor Catherine Noakes in the UK were already concerned that airborne transmission was being "*overlooked by the public health bodies who were focussed almost exclusively on exposure to domestic droplets when people were at close proximity and on the role of contaminated hands and surfaces*" [INQ000236261_0049].

94) In this Module, the Inquiry heard from Rosemary Gallagher, Professional IPC Lead at the RCN. She confirmed that, in her view, aerosol transmission was overlooked, with the result that healthcare workers were placed at unacceptable risk in the workplace [Gallagher; 10/57/1]. IPC guidance prevailed which meant that healthcare workers were not given the Respiratory Protective Equipment necessary to prevent infection due to airborne transmission. The RCN advocated and campaigned for this at the time – this was not a question of hindsight.

95) Dr Eleri Davies prepared the corporate witness statement on behalf of PHW for the Inquiry for Module 5 [INQ000557344]. At §93, she states:

> *"Public Health Wales did not advise the Welsh Government that COVID-19 was only communicable following AGPs. We were aware that modes of transmission included droplet/aerosol and contact. Our communications with the Welsh Government were regarding the UK COVID-19 IPC Cell guidance and ensuring that the Welsh Government were familiar with any updates to that guidance."* [INQ000557344_0024]

96) However, during the pandemic, it seems PHW did in fact advise it was only communicable following AGPs, and did advise the Welsh Government that the virus was not transmitted by aerosol transmission. In an email dated 24 March 2020 to the Deputy Chief Medical Officer, Professor Chris Jones, Dr Davis reported:

> *• Based on the current available evidence, the COVID-19 virus is transmitted between people through close contact and droplets, not by airborne transmission. The PPE required for contact and droplet precautions in the UK is Gloves, Aprons, Fluid Repellent Surgical Mask (FRSM) and eye protection (risk assessed depending on risk of splash) — FFP3 masks are only required for aerosol generating procedures (AGPs)."* [INQ000252515_0003].

97) This continued to be the case up until December 2021: in an email of that date to Welsh government colleagues, Dr Davis reported the view that "*the consensus view of the cell was that the IPC guidance as it stands was currently fit for purpose. There was no evidence that the mode of transmission of the virus had changed*" [INQ000252535_0002]. The group is concerned to understand whether PHW did, or not did, advise the Welsh Government on route of transmission, and why there is confusion over this position. The group understands that the Inquiry had limited time and resources available, but nevertheless considers it was a missed opportunity to explore this important issue – in so far as it related to PPE - with a witness from PHW.

Evidence that IPC guidance was driven by resource/constraints in supply

98) Secondly, there are serious concerns as to why IPC guidance sought to limit the use of FFP3s, in particular, the extent to which IPC guidance was driven by supply/resource

constraints, rather than the health and safety of healthcare workers and patients. It is well known that FFP3s cost much more per unit than fluid resistant facial masks (Type IIR masks): in Wales, the average unit price for FFP3 ranged between 10 to 110 times the average unit price of Type IIR masks over the period November 2019 to October 2020 (calculations based on data from NWSSP summarised in the report of John Manners-Bell [INQ000474864 at §329; Table 3]). Plainly, the issues with supply and resourcing impacted the IPC guidance:

a) Professor Jonathan Van Tam acknowledged in an email to the HSE on 23 January 2020 regarding appropriate levels of PPE that, whilst the maximum level Respiratory Protective Equipment was required: "*this was neither affordable nor practical for pandemic stockpiling*" [INQ000151353]. And on 20 March 2020 Professor Van Tam called for, "*a proportional plan for sensible prioritised use of what PPE we have and can get. In other words, given the science, given the reality of stocks, how can this be prioritised in the most sensible, risk-stratified way"* [INQ000381179].

b) Professor Catherine Noakes explained the reluctance to properly acknowledge airborne transmission, despite a growing evidence base, as (in part) a result of "*the significant resource and operational implications it would have for hospital infection control measures…"* [INQ000236261].

c) Dr Claas Kirchelle explained that cost-cutting considerations "*dominated*" decisions in respect of critical PPE, particularly FFP3s [INQ000205178_0090-92].

d) Specialist Practitioner Laura Imrie, a member of the IPC cell who gave evidence on behalf of Antimicrobial Resistance and Healthcare Associated Infection ("**ARHAI**") in Scotland, said that *"If we wrote guidance as a precautionary principle to put everybody into FFP3 then not only would they have had a large amount of the workforce that couldn't comply with the guidance, and therefore couldn't come to work, we would also have had high risk areas…that might have been left without the FFP3s…there was at the beginning of the pandemic a very quick and a rapid stocktake of what stock we held and what was required, and from my understanding that would have made it really difficult to supply the FFP3s to ITU units and other areas we deemed high risk"* [05.11.2024/149:17 – 05.11.2024/150:8].

99) Such concerns were felt on the ground, at local authority level in Wales. Dr Chris Llewelyn, Chief Executive of the WLGA observed in his witness statement that:

"*local authorities were uncertain what to purchase and at what scale — it appeared that guidance was driven by what was available on the market rather than by products which were fit for purpose or achieved the conditions to limit the spread and impact of Covid-19*" [INQ000518355_0015 at §33].

100) A briefing note from Chris Jones, DCMO for Wales, dated 13 January 2021 confirmed that:

"*FFP3 masks are relatively challenging to procure, certainly global production would not be sufficient to meet an increase in demand"* and *"UK IP&C guidance must be followed across the UK and that to allow the wider use of FFP3 masks would not only be inconsistent with the evidence, but also threaten the availability of such items for areas where they are evidence based and effective e.g. ITUs*" [INQ000473726].

101) Thus, the CBFJ Cymru remain concerned that, as far as IPC guidance is concerned, the emerging picture is one of supply-led guidance, rather than guidance-led supply. Given guidance determined the procurement strategy, the result is that many healthcare workers in Wales were given a level of PPE insufficient to protect them, and their patients, from the virus. And this was so notwithstanding the growing body of evidence that the virus was spread by aerosol transmission from the early stages of the pandemic.

102) The real impact of IPC guidance on PPE is best understood with examples from people's day to day experiences during the pandemic. Two such examples of appear below:

a) Alan Haigh was an emergency technician for the Welsh Ambulance Service. In February 2021, he attended a patient's home and caught covid. His colleague, Ms Cadi told an Inquest that the Mr Haigh was wearing level 2 PPE. This comprised a mask, gloves and apron, and was the level of protection issued to staff for routine patients. Ms Cadi herself wore level 3 PPE, as she administered the treatment. Both acted in accordance with guidance. Clearly, Mr Haigh's level of PPE was not sufficient to protect him, and he passed away from covid.
b) A locally employed doctor told the BMA "*I was redeployed to ICU [Intensive Care Unit] part way through from AMU [Acute Medicine Unit]. The difference in protection was stark. In ICU we had full PPE for anyone suspected and were told by consultants to take our own PPE to any ward patients to protect*

ourselves […] On the AMU side, even though there is an undifferentiated take, self bought masks were not permitted (as they would frighten patients!) until a while after the CDC [Centres for Disease Control and Prevention] and WHO [World Health Organisation] recommendations were made. It was clear that ICU was prioritised and wards were having other 'guidance' to protect PPE levels. This is not equity, and judging by the level of staff COVID sickness in wards compared to ICU, and patient breakouts, there are indicators that staff and patients came to harm during this time due to these differences" (witness statement of Professor Philip Banfield on behalf of the British Medical Association [INQ000562457_0018] at §58).

Conclusion

103) Whilst the CBFJ Cymru is aware the IPC guidance was considered in a previous module, the group urges the Inquiry to address the issue afresh in the context of the cross-cutting issue of adequacy of PPE supply. Professor Catherine Noakes, from whom the Inquiry heard in 2023 explained the reluctance to properly acknowledge airborne transmission was in part because of "*the significant resource and operational implications"* of doing so. Consistent with that, the Audit Wales report put the cost of an FFP3 mask at 110 times the cost of a fluid resistant mask during the pandemic (October 2020). If supply shaped the IPC guidance, as many in the group fear, then no amount of analysis about PPE supply chains and distribution channels would assist in a future pandemic. What matters is that the appropriate PPE – offering the appropriate level of protection – is supplied.

104) It is a matter of very great concern to CBFJ Cymru that the IPC guidance should have been used as a means of rationing the procurement and provision of FFP3 respirators. While it is recognised that, due to inadequate preparation and planning, there were insufficient quantities of FFP3 stocks in the early months of the pandemic, with no immediate means of procuring adequate stocks, this does not excuse the failure of the IPC guidance to recommend that FFP3 (or at least some other form of RPE) was required to be used when treating patients with (or suspected to have) Covid-19. This inappropriate use of IPC guidance had the following consequences:

a) It failed to inform healthcare professionals of the risks they were exposed to in the workplace, by inaccurately advising that surgical masks (that do not protect against airborne infection and are not even classed as PPE) were appropriate protection against a deadly airborne virus.

b) It undoubtedly contributed to the high levels of nosocomial infections in hospitals and care homes, including to patients and healthcare professionals.
c) It artificially supressed the level of use of FFP3 masks and produced false levels of demand against which procurement was based (inaccurately).
d) Once world-wide demand for PPE eased in the summer of 2020, which provided an opportunity to procure enough FFP3 masks in preparation for the inevitable second wave (which proved to be more deadly than the first), this opportunity was squandered because only sufficient quantities of FFP3 masks for use in IPC settings and AGP procedures were purchased (in accordance with the flawed advice in the IPC guidance) rather than the quantities needed to protect healthcare workers and patients in more general settings.

LESSONS LEARNED

Introduction

105) After some introductory remarks, this section on lessons learned considers lessons learned from:
a) The Rt Hon. Mark Drakeford
b) Mr Vaughan Gething
c) Witness who gave oral evidence: Mr Brace, Mr Slade, Mr Irvine Mr Davis.

106) The Inquiry will make recommendations regarding the procurement and distribution to end-users across the four nations of the United Kingdom of key healthcare related equipment and supplies, including PPE, ventilators and oxygen (Final List of Issues; Outline of Scope).

107) The CBFJ Cymru urges the Inquiry to approach the recommendations and/or lessons learned offered by witnesses from the Welsh Government or its "arms-length" bodies with caution. The group observes that the tenor of lessons learned regrettably appears to be one of self-congratulation. Far from offering constructive criticism of Wales' performance in the area of procurement and distribution of PPE and key equipment, which would benefit future generations in the event of a future pandemic, their emphasis has been on Wales' success in procurement of PPE and equipment.

108) Of course, the CBFJ Cymru does not seek to undermine the hard work of many during the pandemic. Nor does it seek to minimise success where it is evidenced (that,

too, would do a disservice to future generations in the event of another pandemic). However, the group observed (what appeared to be) a reluctance to admit problems in Wales and a readiness to attribute the cause of problems to others (typically the UK Government) or to systems and structures beyond their control (poor levels of UK manufacturing, failures in the global supply chain).

109) This is not a concern levelled at one or two witness statements or witnesses. This is a concern levelled at the vast majority of those who have provided evidence, whether written or oral, on this topic for Wales. It is for this reason that the group seeks to emphasise this point to the Inquiry. The official position (for that is what it appears to be) that Wales, after overcoming some initial difficulties, got things right and managed things much better than other parts of the UK, is so widespread that it represents an entrenched culture of belief. This culture is epitomised by leadership of the Welsh Government during the pandemic: the Rt Hon Mark Drakeford and Mr Vaughan Gething, whose "lessons learned" are considered below.

Lessons Learned: the Rt Hon Mark Drakeford

110) Mark Drakeford has provided a witness statement in Module 5 [INQ000528293] at the conclusion of which he sets out his reflections and lessons learned [INQ000528293_0019 to 0021; §§80-91]. The Inquiry will find no assistance there in understanding why those in Wales did not have appropriate or adequate supplies of PPE and equipment and how such problems could be avoided in the future. It is devoid of critical reflection on Wales. Instead, the reflections comprise statements highlighting Wales successes and/or the UK Government's failures. We set out a few salient examples below:

a) In relation to procurement processes, Mr Drakeford reflected "the procurement processes in Wales, were robust, effective and transparent" [INQ000528293_0019 at §80]. This is inaccurate. Not a single PPE contract scrutinised by Audit Wales was published in accordance with required procurement practice [INQxxx].

b) In relation to procurement, Mr Drakeford reflected "the success of the procurement of PPE in Wales was facilitated by the crucial early decision for a Barnett allocation of funding to Wales, rather than funding from a centralised UK pot". Talk of "the success of the procurement of PPE" is vague and inaccurate: what is the "success" to which he refers, when so many, for much

of the pandemic, did not have appropriate and sufficient PPE and healthcare equipment?

c) In relation to the amount of UK funding, Mr Drakeford said "I do not believe there were any issues with regards to the quantity of funding made available for the procurement of PPE and other key healthcare equipment in Wales". The UK Government allocated Wales £1.022 billion for PPE procurement. The Welsh Government managed to spend only £385 million (Slade [14/3/25; 14/74/15]). The question for many is why the Welsh Government spent only one third of what was available on PPE, when so many went without? And where did the rest of the budget allocated to PPE go?

d) In relation to distribution, Mr Drakeford cited the "valuable assistance of the military to review distribution arrangements." [INQ000528293_0019 at §81]. Their review may indeed have been valuable. But it was a one-week review in April 2020, which highlighted that Wales had no handle on stock levels. Distribution remained a problem throughout 2020 and into 2021. Mr Drakeford offers no reflection on why this occurred or how it could be prevented in future.

e) In relation to supply chain issues, Mr Drakeford said there was a need to invest in domestic supply chains and there should be an "articulated industrial strategy from the UK Government". Few would disagree that serious consideration must be given to the resilience of domestic supply chains. But here, in typical fashion, Mr Drakeford's lesson is not for Wales, but for those "particularly within HM Treasury" and the UK Government. The lack of "overall direction or a playbook" for Welsh manufacturers during the pandemic was not the fault of the Welsh government, but Westminster.

f) In relation to integrity of supply processes, Mr Drakeford raised (unspecified) concerns about the "integrity of processes run by the UK government in securing domestic supplies" only to praise the standards of integrity in Wales. Such reflections are vague and unsubstantiated. Whatever the truth of the standards that were applied in Wales, they did not translate to the adequate and appropriate supply of PPE and equipment to those who needed it most.

Lessons Learned: Mr Vaughan Gething

111) Mr Gething has made a statement for this module in which he sets out some lessons learned [INQ000536418]. As with Mr Drakeford, the Inquiry will find no assistance there in understanding why those in Wales did not have appropriate or adequate supplies of PPE and equipment and how such problems could be avoided

in the future. For, like Mr Drakeford, Mr Gething's lessons learned are devoid of critical reflection on Wales.

112) Remarkably, for someone who was the Minister of Health and Social Services, his collection of 'lessons learned' totalled just 300 words, most of which reveal an unwillingness or inability to engage with issues of substance. His "key reflections and lessons" include:

a) "How quickly stores of supplies, in particular PPE, can be exhausted during a pandemic, or similar event of this magnitude…";
b) "The need for broad political and public support if we are to seriously invest in improving the resilience of domestic supply chains…";
c) "The importance of mutual aid between the four nations…"
d) "We should expect a future pandemic to distress national and local supply chains as happened here…".

113) Beyond the statements of the obvious set out above, Mr Gething promotes the Welsh success story seen in Mr Drakeford's lessons learned. Further reflections noted: "The importance of a central purchasing and procurement system which focused on both quality and value for money and, crucially, did so in a fair and transparent way, without preferential treatment." Undoubtedly, a reference to the NWSSP, but a reference lacking any substance. This utopic vision of the Welsh PPE procurement system is betrayed by the facts:

a) the 'call to arms' to Welsh manufacturers to assist with PPE was late: it came on 20 April 2020, well after the shortages on the frontline were being reported [see e.g. concerns raised with the Welsh Government of 22 March 2020 – INQ000395479_0005];
b) PPE was substandard [Slade; 14/70/7]
c) Procurement lacked transparency [Audit Wales report 2021; INQ000214235]
d) And, most importantly, the system did not deliver. Those who needed PPE and equipment did not have it, particularly in the care sector.

Lessons Learned: other witnesses from Wales

114) As to lessons learned from those who gave evidence, the tenor is the same.

115) Mr Brace was asked about his lessons learned. He referred to the Audit Wales report: "*I think the Wales Audit Office report I'd fully agree with their insight and their*

recommendations for the future, so I won't repeat those" [Brace; 6/194/2]. In fact, the only criticism in that report was the lack of transparency in procurement contracts, so that lesson learned does not assist very much. The Audit Wales report was an overwhelmingly positive assessment. Mr Brace also felt better planning was needed, but did not elaborate on this further, save to say:

> *"I've always believed that plans are great but it's people that makes plans work, and we were really fortunate in Wales to have some very experienced procurement professionals sitting within an organisation that had central responsibility for buying, storing, distributing, and fairly sort of joined-up established relationships, and I think they were critical particularly in that phase of the pandemic*" [Brace; 6/194/14].

116) Mr Brace praised "small governance" - which translated to an ability to get ministerial approval quickly and put in place actions really quickly [Brace; 6/194/15-6/195/17]. But small governance did not translate to provision of adequate PPE and equipment to hospitals and care homes, and to that extent small governance did not assist.

117) Mr Slade said "there are definitely lessons that we can learn at a local level" [Slade; 14/86/14] but did not elaborate. Unlike the chief executive of the WLGA, he had no concerns about the Welsh Government's appetite to work collectively and inclusively with those at a local level.

118) Mr Irvine spoke to the need for resilience in the supply chain: a lesson with which few would disagree. He could not help with lessons to be learned on distribution – that was not the concern of NWSSP. As he put it "the more important issue here is to understand what the responsibilities of my organisation are and where they started and where they ended" [Irvine; 14/155/13-14/156/8].

119) And finally, Mr Davis spoke of his lessons learned: "*Governments need arms-length bodies and vice versa to ensure truth is brought to power based on sound information and intelligence*." [Davis; 14/181/10]. As to what that meant in practice – what truth was brought to Welsh ministers during the pandemic by CERET - he said that was "*out of the scope of my role as CERET*." [Davis; 14/181/17]. Regrettably, the group and the Inquiry are none the wiser.

120) Mr Davis reflected that CERET was a success since, "*Wales never ran out of equipment*" [Davis; 14/169/23] but this claim was not scrutinised and the lived experience of many members of the group would cause them to doubt its accuracy.

121) In summary, the group wishes to record its disappointment that the lessons learned from Welsh leadership and those in positions of responsibility appear to demonstrate little critical analysis about what went wrong in Wales. Those that did give evidence seemed more determined to defend the decisions they took than explore ways in which things could have been done better and thus to learn lessons for the future.

CONCLUSION

122) Just four witnesses gave evidence from Wales. Much of their evidence was dedicated to the technical and procedural aspects of procurement. But for the members of the CBFJ Cymru, the concern has always been to understand why those that needed PPE and equipment such as ventilators and CPAPs did not have it. In opening, the group asked why there were such shortages of PPE, why access to ventilators and equipment was inadequate, why the risk of nosocomial infection was so high in Wales, why care homes were overlooked, whether shortage in supply of FFP3 masks influenced IPC guidance, such that healthcare workers were inadequately protected. These questions, regrettably, remain unanswered. Gaps remain. And if gaps remain, and questions remain unanswered, there is of course a real concern that the Welsh Government have not learned lessons for the future.

Covid-19 Bereaved Families for Justice Cymru
6 May 2025

Module 6 of the UK Covid-19 Inquiry

Written closing statement on behalf of the Covid-19 Bereaved Families for Justice Cymru (CBFJC)

Introduction

1. Care homes were one of the least safe settings in Wales during the pandemic, and residents were extremely vulnerable - excess deaths during waves 1 and 2 were approximately 100% and the research of Professor Shallcross and colleagues established that once residents became infected in wave one, there was a 36% chance that they would die [INQ000544928_0001].
2. This vulnerability was well known to the Welsh Government (WG). However, despite this knowledge, elderly people in Wales were neglected. Worse, the claims that WG prioritised elderly people is not supported by their actions, as demonstrated throughout this statement.
3. False claims have been made by WG in connection with their testing policy. In their oral closing statement to Module 6, WG state that it was scientific and medical advice that prevented sooner testing on discharge from hospital to care homes [Day 20/125:18] and, "*that decisions on asymptomatic testing were similarly based on scientific advice available at the time and not based on testing capacity*" [Day 20/126:3-5]. This is not the case. It was a lack of testing capacity and concerns about the impact on staff absences that prevented more widespread testing. Further, CBFJC's closing statement will demonstrate how WG consistently used, 'the science', both during the pandemic and at the Inquiry, as a ploy to evade challenge and accountability.
4. This closing statement is divided into four parts: testing failures; inadequate IPC and PPE; the de-prioritisation of elderly people; and the failure to prepare for the second wave.

First - testing failures

5. Testing decisions and policy in Wales were slow, dysfunctional, reactionary, and false statements were made to justify not implementing testing sooner.
6. Emails from Care Inspectorate Wales (CIW) following a meeting with WG on 22 April 2020 record that "*testing arrangements are fragmented and differ across Wales*", there is "*no central lead for testing*", and "*no one could answer the question who or what organisation is in charge*" [INQ000198307]. Similarly, Professor Khaw confirmed during his evidence that there was a disconnect between Public Health Wales (PHW) and WG at the end of April around some of the decisions [Day 6/144:19-21].
7. The WG's position on testing at the Inquiry has two key features. First, that the risk of discharging untested patients into care homes did not come to the fore until 15 April [Module 7 Day 1/124: 7-9]. Second, that it was not until 12 May that the balance tipped

in favour of a programme of testing asymptomatic care home residents and staff [Module 7 Day 12/164:3-8]. The WG maintains that scientific and medical advice precluded earlier testing in both these areas, as follows, "*General asymptomatic testing in care homes was not introduced before 16 May because the advice received up to that point by the Welsh Government was that the scientific evidence did not support it. You also heard in evidence that the advice relating to asymptomatic testing of all care home residents that was referred to by Matt Hancock in a Health Minister's meeting on 5 May 2020 was never shared with the Welsh Government at any level nor were its contents reflected in SAGE advice at that time*" [Day 20/126:12-21]. CBFJC submits that these positions and statements are false. Scientific evidence (including advice from SAGE) did not support WG's position, and there was widespread sharing of information between the UK Government and WG.

8. Testing on discharge and routinely in care homes was required because of the vulnerability of care home residents and the risk of asymptomatic transmission. In Module 7 Professors Fraser and Nurse told the Inquiry that the evidence of asymptomatic transmission "*emerged quite clearly throughout February and March 2020*" [Module 7, Day 2/199:19-20] through studies from China, Hong Kong, Italy, and the cruise ship Diamond Princess [Module 7, Day 4/32:16-19]. And Professor Harries said that, "…*asymptomatic testing and the risks were completely understood, I think, in March…there was a particular study in the US, in the Seattle care home* [INQ000224063]*, which gave a lot of strong evidence with very good data and denominator factors of asymptomatic transmission, and then PHE actually did what's known as an Easter 6 study* [INQ000320602]*, in the Easter weekend, which gave us…home grown UK figures for the first time, which were really robust…"* [Module 7, Day 10/142:6-18].

9. This evidence was not hidden from WG - it was publicly available and well understood. And it is clear that the First Minister, Mark Drakeford, was aware of the dangers to care home residents from statements made in the Senedd in March 2020: on 3 March 2020, "…*what we know about the virus is that its impact is more significant amongst older people and people's whose immune systems are already compromised because of other conditions. And those people are to be found in greater concentrations in residential and nursing homes*" [INQ000321248_0012]; and again on 24 March 2020, when Mr Drakeford warned, "…*most people will experience a very mild episode of this illness…The problem is that while you are asymptomatic you could be passing the virus on to somebody who is much more vulnerable*" [INQ000420992_0020].

10. Given the extreme vulnerability of care home residents to Covid-19 infection, a proper precautionary approach demanded asymptomatic testing both on discharge from hospital, and routinely within care homes, at the earliest opportunity.

11. The WG decided against this precautionary approach and chose to prioritise what little

testing capacity it had elsewhere. But rather than own and explain this decision at the Inquiry, they have hidden behind 'the science'.

12. 1,088 patients were discharged from hospital into care homes in Wales, prior to the introduction of testing on discharge on 29 April 2020 [INQ000271757_0008], which seeded infections into vulnerable communities. The extent of this practice goes beyond the failure to identify asymptomatic infections and includes knowingly transferring patients, who had either tested positive or were suspected to be infected with Covid-19, into care homes, raising ethical issues, such as:
    a. The circumstances explained by the CBFJC impact witness, Alison Sibley [INQ000614374], whose mother, Rosalind Brockbank, was admitted to hospital on 4 March 2020 following a fall, and while there acquired and tested positive for Covid-19. Despite continuing to exhibit symptoms of Covid, and a physiotherapist recording in her medical notes that she was not fit for discharge, she was nevertheless transferred to a residential care home without a further test. She died from Covid-19 on 17 April 2020 after 11 days of deterioration following her discharge from hospital.
    b. An email exchange between the Association of Directors of Social Services Cymru (ADSS Cymru) and Swansea Council on 14 April 2020 [INQ000511731]: "*Swansea have experienced: 1) Discharge to dom care where we weren't informed that patient had been tested. Subsequent result of test was positive. Was back before we had much of a grip on PPE. Risked infection of a number of staff and other care recipients. 8 staff ended up in isolation. 2) Patient discharged to a care home. Were tested as positive. Not symptomatic. Care home weren't aware until after the individual died and GP turned up in space suit saying that they could see on the records that the individual was positive for covid infection…Having a meeting about the ethics of knowingly transferring infection into a care home setting later this week*".
    c. Email correspondence between Care Forum Wales (CFW) and WG on 2 March 2020 proposing to "*facilitate faster discharge from hospital and the use of care home beds to free up space in our hospitals…*" [INQ000183761].
    d. Concerns expressed by CIW to WG on 8 April 2020 in relation to proposed guidance advising and encouraging care homes to accept patients from hospital including those that might have Covid-19 whether symptomatic or asymptomatic, and querying how care homes could safely care for patients with Covid-19 and protect the other people living in the home [INQ000198288].
13. In respect of routine testing, WG refused to accept the need for routine testing in care homes to combat widespread asymptomatic transmission, despite a wealth of published scientific evidence by the end of March/early April 2020 that significant asymptomatic transmission was occurring (to which care home residents were particularly susceptible

and vulnerable). The UK Government was slow to respond to this risk but did at least recognise it by 14 April 2020 within GO-Science advice of this date that confirmed that asymptomatic infection "*is common and represents a large proportion of disease transmission…Intensive track-and-trace testing efforts, including of asymptomatic individuals, are thought to be core to the successful disease control efforts in South Korea, Hong Kong, and Singapore…*" [INQ000087177_0001-2]. The UK Government went on to announce routine testing for care home residents and staff on 28 April 2020 (almost three weeks before WG, which delayed until 16 May).

14. Meanwhile in Wales, WG tied itself in knots trying to justify its lack of action, and the former First Minister, Mark Drakeford, made false statements in the Senedd when claiming on 29 April and 6 May 2020 that there was no clinical value in routine asymptomatic testing in care homes. On 16 May 2020, WG finally changed its position and announced routine testing in all care homes. However, this did not take place immediately and was of a one-off nature for residents. It was completed by mid-June 2020, but only after the huge loss of life experienced in Wave 1.

15. The WG claims that this change of approach could not have been taken prior to 12 May 2020 when 'new' advice was provided within the meeting and minutes of SAGE 35 that, "*extensive testing of both residents and staff is* ***crucial*** [emphasis added] *both in care homes which have reported cases and those which have not*" [INQ000215622_0002]. But this was not new advice at all. SAGE meeting minutes from 14 April 2020 repeatedly warned of significant transmission in hospitals and care homes and the need for increased testing in these settings. For example, at §11 of the minutes of SAGE 25 on 14 April 2020, "*SAGE advises that increased testing in these settings, supported by modelling, is important*". Further examples at SAGE 26, 28, 29, 30, 33, and 34 can be found within CBFJC's written closing statement to Module 7 at §51. The real reason that the WG introduced routine testing following SAGE 35 was not because the SAGE advice was new, but because it had become completely untenable to perpetuate further WG's false claim that there was no clinical value in asymptomatic testing.

16. It was blindingly obvious to those on the frontline from early in the pandemic that routine testing was needed in order to prevent and control transmission in care homes. The Inquiry heard from Helen Hough, the owner of a care home in North Wales, about its importance and her efforts to secure testing, including within her email to her assembly member and the Minister for Rural Affairs and North Wales on 1 May 2020 (which Ms Hough requested be shared with Mark Drakeford and Vaughan Gething): *"…without anyone being tested, we do not know who has it, and who does not, so the risk of transmission is exceptionally high, especially as we are discovering with this very new disease that people can be asymptomatic but still test positive, therefore we do not know who is carrying this into the building, and that is why COVID-19 is 'spreading like wild fire'*

in Care Homes…I do not know how long it is going to be before relatives of the deceased speak to one another and realise they are not being treated with the same importance as England (less than 9 miles from here) and as the Prime Minister of the UK want them to be treated. Relatives are assuming these tests are being carried out as they see it on their national news…and [would] be horrified to learn that the Welsh Government has decided it's not important enough" [INQ000598470].

17. Testing capacity in Wales in mid-March was just 500 tests per day across the whole country and only 15 tests per day were available to Welsh local authorities with which to test their social care staff [INQ000569773_0092]. By April, capacity had increased marginally to 1,000 tests per day on 9 April 2020 [INQ000312371_0002], 1,800 tests per day as at 20 April 2020 [INQ000253584_0001], and 2,100 tests per day by 29 April 2020 [INQ000501510_0003]. This lack of capacity was the real reason testing could not be introduced sooner and blaming scientific uncertainty is simply a convenient means of avoiding responsibility. This cynical approach is now clearly exposed at the Inquiry by the following evidence (set out chronologically).

18. Within the witness statement of Albert Heaney, it is stated at §309, "*I, along with policy colleagues in my directorate, was concerned at the conflict between expediting hospital discharge to create capacity, and potential risks arising by returning or placing people vulnerable to the effects of Covid-19 back into care homes. This was a very difficult situation where decisions could only be taken by considering what was known at the time. It was clear that if discharges were not made, hospitals would not be able to function effectively which would inevitably lead to increased deaths. In the absence of advice to the contrary from health experts, the Deputy Chief Medical Officer (Wales), Public Health Wales, and evidence regarding the possibility of asymptomatic transmission; while testing of all patients upon discharge would have been preferred, without sufficient testing capacity it was not possible*" [INQ000551798_0088-89]. Despite this clear and detailed account of Mr Heaney's wish to introduce testing on discharge but for a lack of capacity, Mr Heaney resiled from this position in his oral evidence to the Inquiry on 15 July 2025. While confirming that the capacity to undertake "*wider-base testing*" did not exist until May and June 2020, Mr Heaney explained that in fact the decision that he made on 8 April 2020 not to test all patients on discharge from hospital to care homes was based on "*medical and scientific advice*" and that the statement to the contrary made within his witness statement at §309 (quoted above) was Mr Heaney's view, "*in hindsight*" [Day 10/139:1-140:17]. While not doubting the sincerity of Mr Heaney's concern, CBFJC does not accept this explanation, and the attempt to reconcile the statement, "…*while testing of all patients upon discharge would have been preferred, without sufficient testing capacity it was not possible"* with the position of WG at the Inquiry that they were following the science, is not credible.

19. The preliminary findings of the Public Health England (PHE) Easter 6 study was shared with the UK Senior Clinicians Group (which included the Welsh CMO, Sir Frank Atherton and DCMO, Dr Chris Jones) "*as soon as these were available, in the week commencing 13 April 2020*" [INQ000309002_0023]. The PHE report of this study, titled, "The Easter 6 Care Home Investigation" [INQ000320602] found that of the 218 residents, 107 (49.1%) were SARS-COV-2 positive of whom 51 (47.7%) did not develop any symptoms during the two weeks before or after swabbing. 20% of the staff tested positive, of whom only approximately 20% were symptomatic.
20. Shortly after this meeting, on 15 April 2020, an email was sent from WG to PHW that stated, "*Just to alert you that CMO and Albert Heaney want a revised approach to testing in place asap which will include testing on hospital discharge to care homes and more general testing for care home residents and staff*" [INQ000520929]. CBFJC suggest that this request for testing on discharge and more generally in care homes was likely in response to the GO-Science report of 14 April and the PHE Easter 6 study.
21. The 15 April email was followed by an email exchange between WG and PHW on 16 April 2020 [INQ000598625] which states, "*CMO and Albert Heaney want a revised approach to testing in place asap which will include testing on hospital discharge to care homes and more general testing for care home residents and staff. They wish to communicate this tomorrow. As you can see from the numbers below there does need to be a significant increase in testing capacity to deliver on this given the commitment already given to LRFs to test key workers. Can you confirm that PHW are on track to deliver 2207 tests as of Monday 20th?*" To which, PHW replied, "*We are working to clarify our testing capacity, which is increasing sequentially over the next days and weeks…I'm not sure that there will be a significant mismatch between demand and capacity*".
22. PHW interpreted the WG emails of 15 and 16 April 2020 as, "*the Welsh Government's Social Care colleagues were relaying a message from the CMO and Albert Heaney, that they wished to write out to care homes and advise that Wales would also be testing patients prior to discharge and testing all symptomatic residents in care homes…[however] we still had not had any discussion with the CMO about this proposed change* " [INQ000587702_0057]. Further, Giri Shanker of PHW replied to Alison Machon (WG Head of Regulation and Inspection Policy) on 16 April 2020, as follows, "*I have not been involved in any discussions with CMO on this…I want to be very clear that (1) Just because PHE have changed their guidance, it does not mean we have to (2) If we were to follow the English guidance,* ***we certainly do not have the testing capacity to meet the revised requirement*** [emphasis added]" [INQ000617081].
23. At §203 of Professor Khaw's statement [INQ000587702_0057], it is stated, "*Andrew Jones from Public Health Wales had also attended a meeting with the then Minister for Health and Social Care and Local Authority Leaders on 16 April 2020, where the Minister*

for Health and Social Care presented a different position on testing based on CMO advice". This account is corroborated by the email of CIW of 16 April 2020 [INQ000501494] in which Gillian Baranski, the Chief Inspector, expressed her concern at Mr Gething's comments, "*Hello Frank, I was at a meeting earlier today with the leaders of local government and Vaughan Gething. Covid 19 testing for people discharged from hospital back to care homes was the main focus of the discussion which became quite heated. The Minister insisted repeatedly he was following your advice as CMO that asymptomatic people did not need testing before being released to care homes. There was much consternation expressed by the leaders of local government and I imagine there will be further and repeated discussion about this going forward. You will be aware of discussions we had last week with PHW colleagues when we voiced our significant concerns about this. We are aware that in England they will shortly be testing everyone released from hospitals to care homes (both symptomatic and asymptomatic)*". Either the CMO was instructing PHW to introduce testing on discharge while simultaneously advising Mr Gething that there was no need to do so, or Mr Gething had misrepresented the position. There is no witness statement from Sir Frank Atherton in Module 6, and his statement in Module 7 is noticeably silent on the issue of asymptomatic transmission over this crucial period.

24. An email between Mr Gething and Dr Rob Orford (Chief Scientific Advisor for Health) over the course of 16 April to just past midnight on 17 April 2020, to which Sir Fank Atherton was copied [INQ000530887], makes clear that Mr Gething knew that testing on discharge from hospital was being prevented because of a lack of testing capacity and not by reason of scientific and medical advice. Within this chain, Mr Gething states, "*I want clarity and an explanation about where we are, where we expect to be this week and at the end of next week. I will go out and do the public explaining but at this point I haven't been told why we had commitments that we cannot meet and I do not have a sustainable position to offer on increasing capacity and usage*" [INQ000530887_0005]. Mr Gething also specifically requested an explanation of, "…*the plan expected to deliver and when in April*", and for care home testing of staff and residents and the testing of care home residents on release from hospital to be added to the testing review [INQ000530887_0001]. Dr Orford's replies within the chain include notification of the extremely high rate of Covid-19 positivity within care home residents and workers (from what little testing was taking place in Wales) at 48% and 52.5%, respectively [INQ000530887_0003], and that Wales had managed to perform 1,000 tests on 15 April 2020 [INQ000530887_0004].

25. On 17 April 2020, Dr Orford provided a briefing note to Mr Gething [INQ000384410] that contains the following statements: "*Testing to tell you have coronavirus if you have the symptoms of COVID-19 is not that helpful,* ***unless you work with vulnerable people or***

patients [emphasis added]" [INQ000384410_0001-2]; "*In order of priority and areas of greatest need for testing are (1) Testing in healthcare and social care settings to reduce harm*" [INQ000384410_0002]; "*We know that we have [to] test more people in the healthcare setting, patients and staff alike as well as in the social care setting both residents and social care workers where greater harm may arise from infection*" [INQ000384410_0002]; "*Our initial plan to deliver five thousand tests a day has been hit by global supply chain issues…Two weeks ago, I committed further monies, to bring in further equipment and reagents to increase our testing capacity. We have not announced the additional tests per day that this will bring us as the media will crucify us again if we are late by a week…We have deliberately made different decisions about mass testing than others*" [INQ000384410_0003].

26. On 18 April 2020 PHW met with PHE to discuss the results of the Easter 6 study, a note of which meeting is at INQ000191663. Later that day, PHW held their own separate meeting to discuss ideas for a Wales approach and produced a note of this meeting [INQ000384504] that includes the following statements: "*COVID-19 has proved highly infectious in closed settings…once 3 or more cases are reported, there is around 50% prevalence in both staff and residents despite apparent use of PPE…most care homes will become affected over the next 6 weeks…There is also evidence of underreporting in deaths and of a rise in deaths in the care home setting…Possible measures to consider include: Prevention of entry into the home and more testing in staff, including asymptomatic*". This note was shared with the WG immediately (such was its significance) and prompted the drafting of Ministerial Advice.

27. Within an email chain over 17 to 19 April 2020 [INQ000384521], the following statements are made. On 17 April 2020, WG instructs that "*NHS Wales and PHW in support of the prevention and management of COVID-19 in care homes will provide the following: (1) Discharge testing to all patients being transferred from secondary care to care homes…(3) Rapid response to care homes who report possible case or cases…In support of the above PHW are requested to provide a brief paper on the mechanisms by which both staff and care homes will have access to prompt testing and support*" [INQ000384521_0004]. Then on 19 April 2020, Andrew Jones of PHW emailed WG colleagues, stating, "*clearly there are requirements of HBs and trusts e.g. in relation to patient testing prior to discharge and in using CTUs for testing of care home staff*" [INQ000384521_0002]. To which Dr Gillian Richardson (then Professional Advisor to the CMO) responded later on 19 April 2020 to PHW and WG colleagues, "*There have been 2 meetings also with England on Care Homes yesterday and one scheduled today which Chris Williams is attending from PHW. The situation is one which is rapidly emerging, as we now know that most Care Home infections are occurring through Staff. Where 2 resident infections occur in fact usually half of staff will have had Covid19 (many*

asymptomatic). Enclosing the meeting notes. Expect guidance will be issued formally soon". The two documents attached to this email chain are believed to be the note of the PHE/PHW discussion on 18 April 2020 [INQ000191663], and the note of the subsequent PHW meeting, also on 18 April 2020 [INQ000384504].

28. PHW produced a proposal for the management of Covid-19 in care homes on 20 April 2020 [INQ000520962]. This document includes the following statements, "*It is clear from experience within the enclosed settings cell and from recently completed epidemiological investigations in England that infection is widespread within care settings and that transmission within the settings is rapid and difficult to contain. Rapid, proactive and consistent action is required as soon as the first symptomatic case is identified.* ***Even in these circumstances the level of infection may already be significant among asymptomatic individuals*** [emphasis added]" [INQ000520962_0002].

29. On 20 April 2020 there was a Senior Clinicians Group Meeting, for which a PHE paper of the same date on the prevention of Covid-19 in care homes was circulated (including to Sir Frank Atherton). The paper states, "*By the time an outbreak is reported, the SARS-CoV-2 infection can be widespread in the home…Modelling suggests that the key vehicle for the spread is the movement of care home staff…public health advice is only likely to have a small impact during an outbreak and there may be greater benefits in supporting care homes to prevent introduction*" [INQ000348275_0005]. The paper lists potential measures in response including, an occupational health screening/testing for asymptomatic staff on a regular basis to pick up asymptomatic positive staff early and exclude them [INQ000348275_0007, and 0009].

30. At a meeting with Albert Heaney on 23 April 2020, Directors of Social Services queried when testing on discharge and asymptomatic testing of care home residents and staff would be implemented. CIW indicated that they wished to see these actions as soon as possible [INQ000198308].

31. On 23 April 2020 there was a Senior Clinicians meeting attended by the Chief and Deputy Medical Officers and Chief Nursing Officers from across the UK, including Sir Frank Atherton (Welsh CMO), Dr Chris Jones (Welsh DCMO), and Jean White (Welsh CNO). The minutes [INQ000068951] record an update on care homes that included the following statements by Paul Johnstone of PHE, "*There is a lot of asymptomatic transmission in care homes…Review of international evidence identifies effective actions including hand hygiene; environmental decontamination; staff rotation with staff allocated to one facility consistently; testing of care home residents and staff…symptoms are not good indicators of cases in elderly/care home residents*" [INQ000068951_0002]. The update on testing by Aidan Fowler (Deputy Chief Medical Officer for England) included the following information, *"[testing] capacity will be used for surveillance, and possibly symptomatic community testing, track and trace, and asymptomatic testing of all NHS and social care*

staff. But opening up testing too much may overwhelm capacity" [INQ000068951_0003]. A report authored by Mr Johnstone summarising the international and UK evidence on outbreak management in care homes, titled, 'COVID-19 in care home settings: Enhanced Prevention and Outbreak Management' [INQ000089662] was also considered at this meeting. This paper refers to the CDC [INQ000224063] and PHE Easter 6 studies [INQ000320602], and also a study from Singapore by Tan *et al*. The paper reaches similar conclusions to the GO-Science paper of 14 April 2020, and states "*there is asymptomatic transmission of COVID-19 in care homes among both residents and staff*", and "*by the time a single symptomatic case is identified in a home, the virus will already be circulating in the home amongst residents and staff"* [INQ000089662_0003]. The paper lists actions that are likely to be effective as advised by the UK Centre for Evidence Based Medicine from a review of international evidence, including, "*Testing of care homes residents and staff supports the home to rapidly respond and put additional measures in place to contain and prevent further spread*" [INQ000089662_0002]. The paper also states, "*Among countries that appear to have had success in preventing COVID-19 entering into care homes, such as Singapore and South Korea, there have been very strict processes to isolate and test all care home residents and staff who not only have symptoms, but who may have had contact with people who have COVID-19*" [INQ000089662_0003].

32. On 24 April 2020 Dr Chris Jones sent two emails to WG, PHW and CIW colleagues, captured within the email chain [INQ000336445]. The first timed at 10:29 states, "*This is the English care home paper, discussed with the UK Care Minister yesterday and senior clinicians last night*" [INQ000336445_0002] (believed by CBFJC to be Mr Johnstone's paper referred to in §31 above). The second is addressed to PHW colleagues, Andrew Jones and Julie Bishop, and states, "*I know you are currently working on revising the PHW guidance for residential settings in light of discussions over the last week and are also considering the attached PHE update document shared this morning. Albert Heaney is very keen that this is done urgently and guidance issued…Albert has also said he wants: "Global testing of residents; Staff testing addressed; Dom support work testing*" [INQ000336445_0002]. This email prompts a response from CIW that "…*all staff (and residents in care homes) should be tested whether they are asymptomatic or not and in truth these tests need to be repeated at regular intervals*" [INQ000198311].

33. On 24 April 2020 PHW produced updated draft guidance to prevent Covid-19 in residential care settings [INQ000395608]. Inexplicably, this guidance does not require a negative test upon discharge, and it advises that positive symptomatic patients can be discharged to a care home subject to isolation [INQ000395608_0004]. Further, the guidance allows for the testing of symptomatic residents only, and states, "*Where capacity allows further testing of residents will be undertaken"* [INQ000395608_0008]. At §227 of his witness statement, Professor Khaw describes the reasons for this approach

as, "*the guidance was drafted to reflect this pragmatic approach while the system scaled up capacity…PHW's concern was…without any clear indication of prioritisation in situations where capacity had not yet been scaled up, would have put people at greater risk*" [INQ000587702_0064]. At §230, Professor Khaw further explains the difficulties encountered as, "*Welsh Government Officials were requesting changes to Public Health Wales guidance, which were not wholly consistent with the formal Welsh Government policy communications at the time*" [INQ000587702_0065].

34. On 25 April 2020 Professor Sir Chris Whitty emailed colleagues "*I was v struck by this paper from NEJM yesterday. It's from the US and not strictly comparable, but I think gives some feel for the burden of asymptomatic carriage*" [INQ000229085_0001]. The paper referred to was published on 24 April 2020[1], and concludes that, "*More than half of residents with positive test results were asymptomatic at the time of testing and most likely contributed to transmission*".

35. On 26 April 2020 guidance was provided by DHSC Social Care Testing Cell [INQ000478887], which includes the following information, "*The continuing growth in testing capacity has opened up new opportunities for testing targeted at particular priorities, including - in particular circumstances - testing of individuals not exhibiting symptoms. This has been enabled by a change in Public Health England guidance (approved by the Chief Medical Officer) this week, confirming that there is no barrier to testing asymptomatic people where clinically appropriate…Used in the correct circumstances, testing of asymptomatic individuals can have a number of benefits, including: - Developing understanding of prevalence and incidence of infection and how both change over time. - Exploring key vectors of transmission and effectiveness of public health interventions. - Supporting infection control, providing an ability to proactively identify those who are yet to develop COVID symptoms*" [INQ000478887_0001-2].

36. On 28 April 2020 Alison Machon emailed PHW [INQ000520936_0001] and expressed dissatisfaction with the draft PHW guidance of 24 April 2020 [INQ000395608], stating that it "*is not consistent with the 2 letters issued by the Deputy Director General* [Albert Heaney] *and CMO* [Sir Frank Atherton] *last week, the paper on care homes from PHE last week which identified two sources of infection as staff and hospital discharge…**It also doesn't pick up on the areas Albert has asked to be addressed in terms of global testing of care home residents and staff testing including to identify risk from asymptomatic staff*** [emphasis added]*"*.

37. In a separate email of 28 April 2020 [INQ000396501], Ms Machon communicated the above dissatisfaction to Mr Heaney and Sir Frank Atherton, to which Sir Frank replied, "*I*

[1] Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility, New England Journal of Medicine: https://www.nejm.org/doi/full/10.1056/NEJMoa2008457.

thought we had agreed to test all hospital discharges and all ***symptomatic*** *residents and staff but not asymptomatics*" [INQ000396501_0002]. Within this chain, once again, CIW advocate strongly in favour of regular asymptomatic testing, stating, "*the idea of asymptomatic staff and residents spreading the virus would be an unacceptable risk*" [INQ000396501_0002].

38. On 28 April 2020 PHE circulated an options paper by email [INQ000396502_0003] to PHW that advised of DHSC's intention to roll out "*regular* ***screening testing*** *of ALL residents and staff in care homes, regardless of whether they have symptoms or signs suggesting COVID-19 infection".* PHE's email and options paper was subsequently forwarded the same day to WG colleagues, including Sir Frank Atherton, Dr Gillian Richardson, Dr Chris Jones and Albert Heaney [INQ000396502_0001-2]. The options paper [INQ000500175] includes the following statements, "…*the care sector is seeing a large number of cases and outbreaks. One-third of care homes (4,300 in total) have now reported cases or outbreaks of COVID-19; these outbreaks have been associated with mortality of up to 40%*" [INQ000500175_0001] and, "*There are significant organisational issues where a high proportion of staff screened test positive, and asking them to remain off will likely mandate reliance of agency staff…*" [INQ000500175_0002]. On the same day (28 April) at a meeting between UK Health Ministers, Matt Hancock, Vaughan Gething, Jeane Freeman and Robin Swann, Mr Hancock provided an update on testing, including the asymptomatic testing of people in care homes [INQ000279763_0002]. As is apparent, there was extensive sharing between UK governments of information on testing policy both at Ministerial and Senior Clinician level, and suggestions by the WG to the contrary are simply an extension of their strategy at the Inquiry to obfuscate and to blame others.
39. On 29 April 2020, Mr Drakeford told the Senedd when asked about routine testing in care homes, that "*the clinical evidence tells us that there is* ***no value*** *[emphasis added] in doing so*". CBFJC consider it likely that Mr Drakeford's inspiration for this choice of words is an email of Tracey Cooper of PHW from a month earlier, on 29 March 2020, when responding to an email from a Welsh Assembly member, Darren Millar [INQ000336344]. Mr Millar had asked when routine testing of new residents would begin given the vulnerability of care home residents, to which Ms Cooper provided advice (known to be incorrect even then) that, "*If new residents (or existing residents) do not have any symptoms prior to admission, there is no value in testing for the presence of the coronavirus*". This response was brought to the attention of Dr Andrew Goodhall (Director General Health and Social Services) on 30 April 2020, who commented, "*given broader questions about care homes and testing this is a helpful reference point for current testing regime*" and brought it to the attention of Mr Gething to be similarly deployed.
40. A notebook entry of Jane Runeckles (SPAD) [INQ000327608_0032-0033] records a meeting between Mark Drakeford, Vaughan Gething, Sir Frank Atherton, Dr Rob Orford,

and Dr Chris Jones on 30 April 2020. The entry records that Sir Frank Atherton and Dr Orford indicated that the approach is to test all that are symptomatic, and that it is not possible to test all 25,000 people in care homes every four days. Dr Orford indicated that some people are infectious before they are symptomatic, and begged the question, "*is there an argument for testing asymptomatic*". Dr Jones suggested that further testing will not tell them any more, and that the approach should be to assume everybody is positive and treat them accordingly. Mr Drakeford remarked, "*what difference does it make to how you are running the care home. Testing gives you information but not a solution*". The CBFJC make two observations about this meeting. First, it is clear that the reason for not proceeding with asymptomatic testing in care homes is because of a lack of capacity (25,000 people every 4 days) and not based on scientific and medical advice (as WG continues to suggest). Second, given the wealth of information within the knowledge of WG at this date about the need for asymptomatic testing to control infections in care homes, the level of ignorance demonstrated by these most senior decision makers in WG, typified by the statement of Mr Drakeford, "*what difference does it make…*", is astonishing.

41. On the same date, Albert Heaney (who is not indicated to have been present at the meeting on 30 April 2020) caused an email to be sent to NHS Wales colleagues that states, "*Albert Heaney has asked that we provide you an update on Care Home Testing policy for committee today. See attached a draft position paper setting out current status. Claire Rowlands is developing a fuller paper for the FM by this evening, on testing which will include options for expanding testing for asymptomatic individuals as announced by UK Government earlier this week*" [INQ000501509].

42. Also on 30 April 2020, Claire Rowlands, who since 18 April 2020 had been working on a Ministerial Advice on testing policy, following the advice of PHW from 18 April 2020, sent an email to Sir Frank Atherton [INQ000367481]. This email sought Sir Frank's approval for recommendations in the draft Ministerial Advice, including the following statement, "*Discussions with colleagues in Welsh Government and PHW indicate that testing of asymptomatic (or reportedly so) care workers would help to prevent introductions into care homes, and also provide an estimate of community incidence of COVID, and so targeting testing in the following ways (and this is being explored for health care workers): a. Serial testing of care home workers in care homes free of Covid-19. That would involve testing all care home workers in around 700 homes as it currently stands. This would need to be modelled and take time to get up and running…*" [INQ000367481_0001]. Approximately 30 minutes later Ms Rowlands emailed Sir Frank Atherton again, and stated, "*Just seen your other email Frank, so will remove the serial testing bit…*" [INQ000367483]. CBFJC have not been able to locate Sir Frank's reply to email INQ000367481. However, it seems clear that the CMO requested that the scientific advice, that asymptomatic testing of care workers would help to prevent the introduction

of infection into care homes, be removed from the Ministerial Advice. Again, CBFJC have two observations. First, Sir Frank Atherton was in receipt of a wealth of information from the UK Government, PHE, PHW, and his extensive engagement with UK counterparts to know that asymptomatic testing would help reduce infection in care homes. Second, it is reasonable to infer that it had already been decided in advance not to proceed with asymptomatic testing, and the direction to remove reference to the scientific advice in favour of asymptomatic testing was for the purposes of enabling that predetermined outcome.

43. The Ministerial Advice dated 30 April 2020 that was formally submitted for decision [INQ000336477] includes the following statements: "*We also intend to increase testing within care homes as more testing capacity becomes available*" [INQ000336477_0002]; "*There is some evidence to suggest that there are asymptomatic residents who are undetected and be a source of infection: A pilot study recently undertaken by PHE in six care homes in London…results from one care home…75% of residents were positive for COVID-19 but only 25% were symptomatic. 50% of staff were positive but only 29% of these were symptomatic; and a study by the [CDC]…Twenty-three (30%) residents tested positive, of these, 10 (43%) had symptoms on the date of the test and the remaining 13 (57%) were asymptomatic. Seven days after testing, 10 out of 13 of the asymptomatic residents had developed symptoms. This study suggests that symptom-based screening in long-term care facilities could fail to identify approximately half of residents with COVID-19*" [INQ000336477_0004]; "*Modelling suggests that we would need to [sic]* ***25000 extra test per week*** *for care homes to be able to test all residents - that doesn't include care home workers*" [INQ000336477_0004]; "*New evidence from England supports a targeted testing at care homes with outbreaks and larger care homes…Expanding into asymptomatic individuals still lacks the evidence base to support this being the best use of testing capacity*" [INQ000336477_0005-6]. The information within this advice, in particular the findings of the PHE study, makes plain the urgent need to test within care homes asymptomatically and that the reason this cannot be implemented is because of a lack of testing capacity. The suggestion of a lack of 'evidence base' is absurd and is inserted to provide cover for the fact that essential safety measures could not be implemented because of a lack of testing capacity.

44. The WG knew that the case in favour of asymptomatic testing was even stronger than that set out within the final Ministerial Advice, and this does not simply relate to the deletions instructed by the CMO on 30 April. Until at least 29 April 2020 (the day before the advice was finalised) the draft Ministerial Advice contained the following accurate reflection of the scientific position: "*our current policy in Wales is to test all symptomatic residents and staff…Evidence suggests that this approach results in asymptomatic Covid-19 individuals, many of whom will go on to develop symptoms, not being identified and a source of ongoing risk to residents and staff…International evidence suggests that*

increasing testing in care homes for asymptomatic staff will provide added protection against the virus in the sector" [INQ000367477_0007, and 0009]. CBFJC has not been able to determine on whose direction this accurate statement of the science was removed from the Ministerial Advice. It is possible that it was again the CMO, but whoever, CBFJC can only surmise that it was removed to aid the impression that the decision of the WG had some sort of scientific and medical legitimacy, whereas the reality was WG knew full well that they ought to be testing asymptomatically but simply did not have the capacity.

45. In contrast to the approach taken by WG, a WhatsApp exchange [INQ000102062] between Professor Whitty, Sir Patrick Vallance, Matt Hancock, Boris Johnson and Dominic Cummings on 3 May 2020 demonstrates their collective knowledge of the importance of testing in hospitals and care homes at this date, and includes the following statements: "*I don't understand why we are still not testing more NHS staff and care home staff including asymptomatic…we know the most vulnerable are in hospitals and care homes*" (Cummings); "*We should be and we have said that*" (Vallance); "*We have been doing this for the past week"* (Hancock); "*On testing in care homes and hospitals everyone agrees now we have the capacity we should be doing a lot more. It's not a panacea but it would definitely help*" (Whitty) [INQ000102062_0001-2].

46. Whereas in Wales, undeterred by the clear evidence within the Ministerial Advice of 30 April 2020 of the risk to life of asymptomatic transmission within care homes and the need for asymptomatic testing in response, Mr Drakeford doubled down on the false claims made a week earlier, and on 6 May 2020 told the Senedd that he had not seen "*any evidence"* that asymptomatic testing had any "*clinical value*" in homes where there was no coronavirus in circulation.

47. These views are of course absurd, and they were known to be so at the time. Peter Halligan, Chief Scientific Adviser for Wales, caused an email to be sent to Dr Rob Orford and Fliss Bennee on 30 April 2020 upon hearing them on the first occasion, which reads, "*Dear Rob, Fliss, Peter Halligan is keen to understand the rationale, evidence and advice behind the First Minister's comments last night on the telly that there is no value to testing for Cov-19 in care homes. Please can you enlighten us.*" [PHT000000073_0046].

48. Further, the statement made in the Senedd on 6 May 2020 by Mr Drakeford was directly contrary to the following statements that asymptomatic testing did have clinical value, made within the Ministerial Advice of 30 April 2020, as follows: "*Discussions with colleagues in Welsh Government and PHW indicate that testing of asymptomatic (or reportedly so) care workers* ***would help prevent introductions into care homes*** *[emphasis added], and also provide an estimate of community incidence of COVID*" [INQ000336477_0005]; and "*If more on prevention side, testing which shows asymptomatic carriage,* ***could potentially prevent outbreaks*** *[emphasis added] by screening all homes*" [INQ000336477_0010]. In these circumstances, the statements

made by Mark Drakeford raise a serious question about whether the Senedd was deliberately misled.

49. Mr Drakeford was not alone in making such false statements. During a question-and-answer session on 23 June 2020 (reported at INQ000587938, and also publicly available on video[2]) Mr Gething was asked the question, "*The Welsh Government has said that the scientific advice was it would not be a good use of testing capacity to test asymptomatic patients until the end of April. If it was the case that there was a lack of testing capacity that caused this advice, was it the fact that there wasn't enough tests that meant you made the decision to not test people who were going into care homes until the end of April?*" To which Mr Gething responded, "*No…we based our decisions on advice and evidence*". The journalist continued, "*Surely if you'd had enough tests to have been able to test everyone, you should have been testing everybody who went from a hospital into a care home. And it was the fact that you didn't have enough tests that made that advice the advice that it was at the time*". Which elicited a similar response from Mr Gething, "*No…you're just wrong…if we had treble the amount of testing capacity…then that was still the evidence and advice that we had…we didn't get advice that said, 'you really should do this but you can't because you don't have testing capacity'*". CBFJC suggest that the evidence above establishes that a lack of capacity was precisely the reason that asymptomatic testing was not introduced sooner in Wales, and that the public statements made by Mr Gething in his capacity as Minister for Health and Social Services on 23 June, were not accurate.

50. Against this background of dithering, false statements and U-turns, it was difficult for bereaved families in Wales to hear the explanation offered by Mr Drakeford, in his recent oral evidence in Module 7 that, "*we planned first and then we announced. And sometimes that makes us look like we were doing things later than was happening elsewhere, but I believe that our method was more effective*". What was more effective, the group asks, about repeated delays in the implementation of essential safety measures which endangered the lives of so many of the most vulnerable people in Wales? Further, WG was not planning how to implement routine testing in care homes before their introduction on 16 May; it was denying that there was any clinical value.

51. Even once asymptomatic testing within care homes was finally introduced on 16 May 2020 the guidance issued was confused and contradictory. The statement of Vaughan Gething of 16 May 2020 [INQ000182446] stated that testing will be offered to all symptomatic staff and residents who have never tested positive before, with "*testing to be rolled out to all care homes in a matter of weeks*" [INQ000182446_0002], i.e. not

[2] Available online at: https://www.pscp.tv/w/ezWTDDFQWEtkcVlYUE12amV8MUJkR1lucGxlUXpKWLE3rNHhjq9n66M2-KewIRuVYm1X1irTs17IPwFADyn2?t=fRzf-wyHbUrKP8mCtK_gLQ&s=03

immediately. Thereafter, Sir Frank Atherton and Albert Heaney issued a letter to care home providers on 20 May 2020 [INQ000500188] to inform that rapid testing would be undertaken in care homes registered for 50 or more beds within the next two weeks, and that the testing of staff and residents in smaller care homes who do not have a Covid-19 infection will be delivered either by the relevant health board or through the new social care portal, "*which goes live shortly*" [INQ000500188_0002]. The target date for completing testing was 14 June 2020 [INQ000221150] which indicates that this was a one-off rather than repeat testing of residents. On 9 June, Vaughan Gething announced that care home staff would be offered a weekly test for a four-week period from 15 June 2020 [INQ000198394], which was extended in July [INQ000227202], and scaled back to fortnightly from 6 August 2020 with a review in October 2020 [INQ000368201].

52. What this amounts to is one-off asymptomatic testing of residents in care homes between the end of May and 14 June 2020, and thereafter routine testing of care home staff from 15 June 2020, all of which occurred after the first wave and too late to make any meaningful impact. A pathetic response from an incompetent government that failed to communicate the truth of what was happening to the people of Wales.

53. Further evidence that the clinical value of asymptomatic testing was well understood within WG and PHW can be found within the witness statement of Professor Khaw [INQ000587702, §218] in which reference is made to a Journal of Public Health article of 15 May 2021 [INQ000520960]. Although this article was not published until 2021, the findings were based on data collected from care homes in Wales between February and May 2020, and of the six authors, five are PHW scientists. The article finds, "*The delayed and lack of testing early in the outbreaks and delays in isolating residents before they became symptomatic are both likely contributing factors to the extensive transmission of COVID-19 in these homes*" [INQ000520960_0006], and "*Care homes should be enabled to take proactive steps to prevent introduction and transmission of COVID-19, including restricting visitors, universal testing, and isolation of residents as required. Waiting for identification of the first case before taking action does not appear to be a sufficient strategy for preventing an outbreak*" [INQ000520960_0006].

54. This, coupled with the need for adequate IPC, including PPE, RPE, and ventilation, is the key lesson of the awful experience of the pandemic for reducing transmission among elderly vulnerable people in care homes. CBFJC submit that it is clear from the evidence set out above that WG and PHW knew from early to mid-April 2020 of the need for widespread asymptomatic testing in these settings, and that reason it was not implemented was not because the science did not support such action until 12 May 2020, as WG claims, but simply because of insufficient testing capacity. What so incenses the members of CBFJC is that the continued false claims of WG that the policy was based on science and not a lack of capacity is for the purpose of evading responsibility, and in

doing so not only does it demonstrate a lack of integrity and accountability, it risks failing to learn from past mistakes. If the truth is acknowledged, it will be clear that better preparation could have avoided the severity of the impacts of the pandemic, but unless this is done, we are destined to repeat the same mistakes. The tragedy of the approach of WG is that it puts the reputations of a small number of Welsh politicians above the wider public interest.

Second - inadequate IPC and PPE

55. The numerous delays and failures in testing care home workers and residents meant that infection prevention and control (IPC) became even more vital to prevent the spread of Covid-19 within care homes in Wales. However, the reality was that many Welsh care homes were small, and their physical infrastructure created problems implementing IPC measures, effectively isolating residents and ensuring proper ventilation.

56. The Inquiry heard that WG's practice of discharging patients from hospitals into care homes without testing was taking place "*at a time when [PHW was] really clear that isolation provided an additional control measure, so that in the case of any positive or infectious individuals, we were able to also, through that measure, control transmission in that setting*" [Day 6/130:20]. However, this approach failed to take into account that isolation was not always possible in many homes, in particular where residents had dementia. In response to a question from the Chair, Professor Khaw acknowledged the "*real-life situation*" and difficulties for care homes: "*Technically, theoretically, isolation is a good control measure. But practically speaking, in care homes, particularly smaller care homes with highly vulnerable populations, it is difficult. I accept that*" [Day 6/131:15].

57. PHW purported to be "*familiar with the care sector's constraints in some of the care home environments*", and capable of providing "*practical advice on how [a care home] might… maintain infection prevention and control*" [Day 6/113:15]; however, CBFJC question the quality and feasibility of the advice provided to care homes when control measures such as isolation were - practically, rather than theoretically - very difficult to implement.

58. Another control measure, ventilation, was a huge challenge for many care homes and there was a marked lack of support and guidance from WG to help care homes improve their ventilation and air quality. Reflecting on the pandemic response, the CMOs and DCMOs highlighted in the UK-wide technical report that air quality in care homes is not currently well understood, but that it is key to mitigating the impacts of acute respiratory infections in future pandemics [INQ000101642_0303].

59. Professor Rayner, on behalf of the National Care Forum, told the Inquiry of the report commissioned from Eric Fewster, an Independent Water and Environmental Manager, who advised in April 2020 that natural ventilation (opening doors and windows) may not provide the ventilation rate required to significantly reduce airborne transmission risk even in summer, and with windows closed (i.e., during winter months), the only reliable

way of reducing the risk of airborne transmission was to install a mechanical system, such as a ventilation system and/or a recirculating HEPA air filtration system [Day 4/112:14].

60. However, Helen Hough told the Inquiry that her care home did not have a ventilation system, which became more of a problem coming into the second wave: "*By winter, we knew that ventilation was crucial, but we could not keep doors and windows wide open*" [INQ000587639_0015, §69]. Nor did her care home have any HEPA filters and "*[i]n fact, there was never any discussion around HEPA filters within the care home sector – whether before the pandemic or in early 2020…the sector was not at all prepared for an airborne pandemic*" [INQ000587639_0015, §69].

61. The value of HEPA air filtration was recognised in a Summary Brief by the Welsh Technical Advisory Cell (the body that coordinates scientific and technical advice to support WG decisions makers) in July 2020, which stated: "*Control Measures for Airborne Infection: SAGE EMG has already considered that the virus could be transmitted through airborne routes and has included this in relevant papers on transmission and recommendations for mitigating risk…**Good ventilation is well recognised as a primary measure for controlling the risk of airborne disease transmission**. A well ventilated space reduces the concentration of viral load in the air and hence the probability of infection…Evidence to date suggests that poorly ventilated spaces pose the highest risk, so it is recommended that mitigation measures focus on those spaces where ventilation is absent or inadequate…The use of recirculating air cleaners may be appropriate in small spaces where ventilation is poor and cannot be easily improved. **Devices which use HEPA or UV-C are likely to be the most effective**…Ensuring good ventilation of buildings is a particular concern for winter, where cold/adverse weather means that ventilation rates are often reduced to manage thermal comfort [emphasis added]*" [INQ000311892_0047-49].

62. Professor Beggs in his evidence in Module 3 highlighted the study by Conway Morris *et al*, from 22 September 2021, which showed that the use of supplementary HEPA filter air cleaning devices on a hospital ward was associated with greatly reduced SARS-CoV-2 RNA levels in the air [INQ000474276_0057], and in his recommendations, Professor Beggs commented that "*The evidence base in support of portable HEPA devices, in particular, is reasonably strong, since these perform a similar task to mechanical ventilation systems, and as such are a mature well-established technology that is quick and relatively inexpensive to deploy*" [INQ000474276_0013].

63. Despite the clear recognition that Covid transmitted via the airborne route, and that HEPA air filters were a cheap and effective mitigation, there was no support for or recommendations to care homes in Wales to utilise HEPA air filtration coming into the second wave.

64. Other aspects of infection prevention and control were impossible to implement within a

care setting. For example, the guidance that staff distance themselves by two metres from residents was totally unrealistic. Helen Hough said in her evidence: "*It's impossible. To begin with, you can't move anybody on your own. You can't nurse a patient without touching them. But also, you need two carers*" [Day 2/111:10].

65. And a modelling study into SARS-CoV-2 outbreaks in English care homes noted the limitations of its work because it did not consider the effect of staff absence on rates of transmission, which were likely to increase due to remaining staff being overstretched and therefore more likely to carry out sub-standard IPC.[3]

66. Because social distancing and other IPC measures were often impractical or difficult to implement in care home settings, what was needed to minimise transmission of infection to vulnerable residents was the right type and the right quantity of PPE/RPE for care home workers. However, this was a further area where WG inadequately protected care home staff and residents.

67. Despite recognition by WG of the need to provide PPE to care homes as early as 18 February 2020 [INQ000470674], it was not until 19 March 2020 that the remit of NHS Wales Shared Services Partnership (NWSSP) was extended to procure and supply care homes, distributed by local authorities. Those operating at a local authority level, however, felt that WG failed to recognise the needs of social care settings, as it prioritised supply of PPE for the NHS [INQ000518355_0009, §§19 and 21].

68. Guidance was issued to social care providers in a letter from Vaughan Gething on 18 March 2020, which directed that PPE should be worn by staff providing direct care to patients suspected or confirmed as having Covid-19. However, despite this guidance, some care homes in Wales received no PPE until the end of April or early May, and by 7 May 2020, only two-thirds of Welsh care homes had their PPE requirements met by the NWSSP [INQ000587254_0028, §112] – too late to prevent widespread infection and deaths.

69. A study into the introduction and spread of Covid in care homes in Norfolk[4] found that once introduced into the home, the subsequent spread of suspected Covid-19 was largely associated with inadequate access to PPE, most especially facemasks (which is likely to be similar to position facing care homes in Wales). There is ample evidence before the Inquiry that Welsh care homes did not have sufficient quantities of PPE: Helena Herklots (Older People's Commissioner for Wales) told the Inquiry there were inconsistent supplies to care homes [Module 2B, Day 2/124:5]; Chris Llewelyn (Welsh Local Government Association (WLGA)) said local authorities were unable to obtain supply of requested items through NWSSP at points throughout the pandemic, and "*demand for*

[3] Rosello et al. (01 April 2022) - Impact of non-pharmaceutical interventions on SARS-CoV-2 outbreaks in English care homes: a modelling study: https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-022-07268-8

[4] Brainard et al. (28 December 2020) - Introduction to and spread of COVID-19-like illness in care homes in Norfolk, UK: https://pmc.ncbi.nlm.nih.gov/articles/PMC7798982/

PPE was met 'on paper' however in practice the supplies could not be utilised by care professionals" [INQ000518355_0020, §§46-47]; Mr Llewelyn also referred to WLGA survey results that showed a third of local authorities said it was very difficult for care providers to access PPE, with common problems being erratic deliveries and the quality of PPE, and that "*six local authorities said orders of PPE being diverted to the NHS happened very often or fairly often*" [INQ000613908_0065, §175]; CFW wrote to the First Minister for Wales, Mark Drakeford, on 8 April 2020 on behalf of members who run care homes for the elderly stating "*our members feel they are barely receiving sufficient PPE to care appropriate for existing residents*" [INQ000499629_0002].

70. Moreover, the PPE packs prepared and distributed by NWSSP failed to provide the right type of PPE, because of a failure to recognise from the outset of the pandemic (as should have been done in accordance with a precautionary approach) that Covid-19 is transmitted via aerosols. Instead, advice from PHW to WG on 24 March 2020 stated, "*Based on the current available evidence, the COVID-19 virus is transmitted between people through close contact and droplets, not by airborne transmission. The PPE required for contact and droplet precautions in the UK is Gloves, Aprons, Fluid Repellent Surgical Mask (FRSM) and eye protection (risk assessed depending on risk of splash) - FFP3 masks are only required for aerosol generating procedures (AGPs)*" [INQ000252515_0003].

71. The failure to recognise Covid as an airborne respiratory infection, which could be transmitted asymptomatically, had a significant and detrimental impact on the PPE that was advised for health and social care workers providing care to patients with Covid-19. On 16 March 2020 Vaughan Gething advised that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. And within a letter to social care providers on 18 March 2020, following Mr Gething's announcement, it was confirmed that (i) PPE was for those directly caring for confirmed or suspected cases, and (ii) a higher level of PPE was "*unlikely to be needed*" in a social care setting, such equipment only being needed by those undertaking AGPs [INQ000470681].

72. However, FRSM or surgical masks are ineffective protection against an airborne respiratory infection, and FFP3 respiratory protective equipment was needed. Helen Hough was clear on this issue in her statement: "*We were not provided with FFP3 respirators, but I bought them (at great cost) on Amazon. If we thought a patient had Covid-19 (for example, because they had a temperature), we wore an FFP3 respirator instead of a surgical mask. As nurses, we knew a surgical mask would not protect us. They do not fit your face, there are gaps at the side, and they are designed to stop the wearer coughing or passing infection to a patient. They do not prevent a healthcare worker from catching infection from a patient by inhaling infectious aerosols, which is why I was asking for FFP3. I knew nurses in intensive care and critical care wards were*

receiving FFP3…" [INQ000587639_0016, §78].

73. Helen Whately also raised this concern in her oral evidence, when referencing the lower rates of infection among ICU staff who had the benefit of FFP3 respirators, and she described the inadequacy of PPE and RPE in social care settings as not "*good enough in the light of the way Covid spread*" [Day 12/80:7].

74. The need for adequate protection in care homes was raised in an email to Vaughan Gething by a Welsh Government Special Adviser on 7 April 2020, who highlighted that residential and domiciliary care staff "*clean, bathe, dress, feed, change dressings and all manner of close up activity, and the idea that district nurses will enter the same premises fully equipped (as is often observed) and they do not, continues to simply jar*" [INQ000349300_0001]. Yet no action was taken by WG. The failure to recognise that airborne transmission was a significant route of transmission, to recommend the use of RPE, and to provide this protection to care homes, undoubtedly contributed to higher levels of nosocomial infection and deaths within care home settings.

75. These inadequate PPE measures in the IPC guidance remained in place throughout the pandemic. This meant that the lack of appropriate respiratory protection, coupled with the absence of effective testing regimes, and the very nature of adult residential care - which does not allow for social distancing and requires close personal care - created a perfect storm for the virus to transmit rapidly among extremely vulnerable people. This was known from the outset by those on the frontline, like Ms Hough, but ignored by decision makers.

76. Alarmingly the most recent PHW IPC guidance for Acute Respiratory Infections in Wales (2024-25)[5] continues to recommend that social care staff use "*FRSM (type IIR) when working in respiratory care pathways and when clinically caring for suspected/confirmed COVID-19 and Flu patients*" [p.8] and only recommends FFP3 masks "*if an unacceptable risk of transmission remains following the hierarchy of controls*" [p.15]. Given the lack of adequate ventilation and isolation facilities in the majority of care homes in Wales, and the need for the provision of close personal care, the ability to apply a hierarchy of controls in these settings is extremely limited, and in these circumstances the continued recommendation of surgical masks shows how little has been learned from the tragic events of the pandemic, and makes the failures to provide appropriate PPE and RPE all the more indefensible.

Third - care home residents were deprioritised

77. Social care across the UK was described by many as a 'Cinderella' service, including by Alwyn Jones (ADSS Cymru) who said "*consideration of social care in the context of a number of decisions was always later than the NHS…it felt like the initial narrative was*

[5] https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/infection-prevention-control/ari-a-z/infection-prevention-and-control-measures-for-acute-respiratory-infections-ari-for-health-and-social-care-settings-wales-2024-version-30/

around the challenge within the NHS" [Day 15/114:3]. The focus in Wales on protecting hospitals and discharging patients to free up hospital beds resulted in a lack of consideration by NHS staff of the safety and wellbeing of elderly residents of care homes and social care staff [INQ000528094_0033, §4.44].

78. Vaughan Gething, when asked about the widely held view that adult social care is the 'Cinderella' service, responded that, "*I recognise where that comes from because it's relatively low paid but actually it's hugely important…And I think the public don't really appreciate the residential social care sector and the domiciliary care sector, because it is not as visible as the health service*" [Day 10/5:3]. However, this response totally ignored his responsibility as Minister for Health and Social Care to ensure that the decisions taken in the pandemic response, and the public statements made, reflected the importance of the social care sector and those living and working in care homes. The reality is that public briefings and policy announcements consistently focused on NHS capacity and resilience and rarely were care homes mentioned with any urgency or specificity. This absence from the public narrative mirrored their exclusion from WG decision-making. In a letter from CFW to the First Minister on 8 April 2020, they wrote: "*our members [who run care homes for the elderly] across Wales do not currently see the clarity of thinking and delivery of resources to match the stated national focus on protecting the vulnerable, when those vulnerable people are care home residents. At present, CFW is unable to reassure its members, as we have no evidence that Welsh Government - through its agencies - will provide significant resources that would be needed if care homes have (as they will if the virus enters) significant number of residents with the infection*" [INQ000499629_002].

79. Professor Banerjee in his evidence said that, "*If your internal compass faces away from people who are old, then you may be more likely to decide that individuals don't get a test, are sent back to their care homes, or sent back home, rather than afforded the extra care that can be provided in a general hospital*" [Day 15/21:21]. CBFJC submit that this tendency was displayed very clearly by WG and public bodies in Wales, which consistently disregarded the safety and individual care needs of care home residents.

80. This pattern of neglect was not incidental - it was systemic. WG's prioritisation of NHS capacity over the wellbeing of care home residents was evident early in its pandemic strategy. The decision to discharge patients from hospitals into care homes without mandatory testing or sufficient RPE, despite known risks of asymptomatic transmission and the increased vulnerability of care home residents, put those residents at direct risk of infection and death. There was a hierarchy of concern in which hospital capacity was valued more highly than minimising transmission of infection in residential care settings. As CFW put it, in a letter to Mark Drakeford on 8 April 2020, "*the current discharge approach - without tests and without sufficient full PPE - gives the appearance of 'sacrificing' the 20,000 older people in care homes in Wales, quite apart from putting staff*

at risk" [INQ000499629_0002].

81. Testing eligibility and regimes early in the pandemic further illustrate this deprioritisation. The Inquiry heard there was a "*clear prioritisation matrix*" [Day 6/121:24], which included symptomatic residents in care homes but not asymptomatic care home residents or staff. The delay in rolling out routine testing in care homes meant that outbreaks were not detected early, it became more difficult to prevent transmission and those most vulnerable to infection were placed at unnecessary risk.

82. The Equality and Human Rights Commission, which investigated WG decision making around care home residents following a referral by the Older People's Commissioner for Wales, found that "*a number of decisions in the Covid-19 response may have resulted in failures to adequately protect the right to life, including decisions about hospital discharges, admissions to care homes, prioritisation of testing and access to necessary healthcare and treatment".* Their report states that, "*Representative groups have described how the combination of decisions in the pandemic response either ignored care home residents or treated them as expendable*" [INQ000253853_0012, §32].

83. In a similar vein, there is evidence that care home residents in Wales could not always access hospitals when they needed them. Ambulance teams were reluctant to transfer residents to hospital, and almost half of Local Authorities in Wales reported that necessary transfers of residents to hospital were not undertaken. The witness statement of Helen Hough details an ambulance team refusing to take a resident to hospital because they had a temperature, and the ambulance team's instructions that they were not supposed to transport anyone from a care home [INQ000587639_0006-7]. Ms Hough recounted the conversation with the ambulance crew in her oral evidence, "*they said to me,* "*The hospital aren't going to be very pleased with this*", *and I went outside the building and I did say to the ambulancemen,* "*It's not up to you to play God here. You're just taking in poorly patients into hospital. You don't get to decide…who lives or dies in this home*" [Day 2/131:5-10].

84. The blanket application of DNACPR forms on the medical records of care home residents - without discussion with them or their families - was a particularly egregious example of systemic disregard. DNACPR was used as a proxy for 'Do Not Treat', resulting in automatic non-admittance to hospitals and patients not receiving the care and treatment they needed, which may have prevented death. One Welsh care home manager gave the following harrowing account of the circumstances of the death of a resident who did not receive adequate treatment and care: "*For whatever reason, perhaps because they weren't confirmed as Covid-19, or perhaps because sufferers can take a turn for the worst and death can come on quite quickly, no palliative care package was put in place by the GP and controlled drugs were not issued to try to ease them with any possible suffering...[The patient] unfortunately passed away within 24 hours and the manner of their passing has affected some of the staff quite badly with [the patient] struggling to*

breathe and in effect slowly suffocating to death. Nobody should have to die like this. I get the fact that these are extraordinary times and we are in the middle of a crisis, the like of which none of us have seen before. However, there appears to be [a] race by GP's to place DNACPR on lots of individuals, which would mean automatic non-admittance to hospitals and possibly many more examples of these horrific deaths, and with no apparent thought as to how if people suddenly take a turn for the worst how they may be helped to pass in a more comfortable and humane way…Care homes do not have a general supply of stock medication supplies for end of life care, nor access to oxygen. How confident are we that residents and their families understand the implications of a DNACPR?" [INQ000500163].

85. In particular, the lack of oxygen, palliative care and medication to ease the suffering of those dying from Covid-19 in care homes was cruel and inexcusable. CIW raised concerns directly with WG from March and April 2020 about the need to support care homes providing end-of-life care to patients with Covid-19: "*family members will be distraught if they are aware of these details. In these extraordinary conditions it is imperative that people who die in care homes with Covid 19 are treated with dignity, compassion and can be made as comfortable as possible*" [INQ000500163].
86. The directive for GPs to shift to remote consultations where possible in order to reduce the risk of infection meant that interactions between GPs and care home residents were often conducted virtually. Combined with the suspension of non-Covid healthcare services for long periods of time, this shift meant that for many residents, regular check-ups, diagnostics and timely medical interventions were delayed or missed entirely. This had a particular impact on care home residents due to the prevalence of chronic conditions and complex health needs amongst this population. It is CBFJC's belief that this contributed to a significant decline of care home residents through worsening health conditions, undiagnosed illnesses, and, in some cases, preventable deaths.
87. The emotional toll and ethical strain on care home staff were immense, as they were left to manage pain and suffering that could have been alleviated with proper intervention. Ms Hough felt that nobody was speaking up for her patients [Day 2/131:12], and she wrote to WG officials on 4 May 2020, as a "*very distraught tired nurse feeling helpless*" setting out the desperate position facing care homes residents and the disgraceful disparity between their treatment and that of NHS patients: "*We have no oxygen on site…I have tried to get GP's to prescribe it but they give us end of life drugs instead. Relatives would be horrified if they could see how poor their relations are being treated in care homes, but because there is no access to visitors they are not witnessing this…As a patient's oxygen saturation level drops with this disease they are gasping for breath, and we cannot give any oxygen relief at all, and as this is the only treatment for COVID19 this is disgraceful, it is 'on tap' at a hospital so patients in hospital will already [be] receiving better care than what we can*

give at a care home" [INQ000598472].

88. The stark reality is that most Welsh care homes were wholly ill-equipped to look after residents who were very unwell or dying. The Inquiry heard from Gillian Baranski (CIW) that the majority of Welsh care homes did not provide nursing care: "*790 of our care homes [out of 1,053] didn't have nursing and therefore they didn't have access to end-of-life medication and to oxygen*" [Day 5/191:1]. This structural limitation was known to WG and should have informed urgent resource allocation. Instead, WLGA survey results show that 59% of local authorities in Wales reported that residents were not receiving adequate medical treatment and 47% reported that necessary transfers to hospital were not undertaken [INQ000613908_0074-0075, §§193-194]. There is no evidence that these issues were a priority for WG.
89. Routine inspections in care homes by CIW ceased in March 2020, which resulted in a lack of monitoring and understanding of what was happening in those homes. Helen Hough's evidence was that, "*there was no comprehension on the part of the local authority, the [Local Health Board] or CIW as to what we were dealing with on a day to day basis. We were so busy, all the time. And when we started to lose patients, it was devastating for all of us*" [INQ000587639_0013, §62].
90. CBFJC recognise that an initial suspension of inspections in March 2020 was reasonable, but given the desperate and frightening circumstances that care home residents and staff were facing, the suspension of routine inspections throughout the pandemic was inappropriate and CBJFC agree with the evidence of Dr Allen (British Association of Social Workers) that the need for monitoring and inspection was heightened rather than reduced [Day 4/48:21-22]. Gillian Baranski told the Inquiry that by June 2020, CIW inspectors had available sufficient PPE and testing to enable more inspections [Day 5/160:11]. However, routine inspections were not reintroduced in Wales until 4 August 2021 and Wales recorded the lowest number of inspections across all UK nations during the financial year 2020-2021 - just 20% of the number of inspections undertaken in the year 2019-2020 [INQ000587847].
91. Data challenges were another significant issue affecting the care sector and Chris Llewelyn (WLGA) stated, at §124 of his statement, that "*During the pandemic there were several data-related challenges that impacted decision-making, service delivery and resource allocation. This included data availability and collection issues, where there was a lack of real-time data on care home residents, staff absences, and infection rates which made it difficult to respond quickly to outbreaks*" [INQ000613908_0050]. While care homes were required to notify CIW of suspected or confirmed Covid-19 in staff or patients from 12 March 2020 [INQ000569773_0062, §189], testing capacity, patients not exhibiting 'common' symptoms, and asymptomatic infection meant that recorded rates of infection and deaths from Covid were inevitably inaccurate. There were also known difficulties reconciling data held by CIW on the numbers of cases and outbreaks in care homes with

PHW data on notifications of infectious diseases [INQ000569773_0012, §39] [INQ000587702_0037-38, §§123-127]. There was no apparent priority in addressing these issues and Professor Bolton's rapid review for care homes in Wales, published in September 2020, highlighted the challenge of "*a large number of public bodies all looking to play their role in the system but sometimes 'tripping over' each other to collect data and to understand what was happening in specific care homes without obvious benefits to the care homes themselves*" [INQ000253708_0009]. This inevitably led to a lack of accountability for the protection of those in care homes, which must be addressed.

92. Older people in Wales contributed more than any other group to the fabric of Welsh society, and yet their needs and rights were overlooked and dismissed time and again. Despite knowing that older people in residential care and nursing homes were the most vulnerable to Covid-19 infection, they were consistently deprioritised in the decisions taken by WG and public bodies. Simply because of age or cognitive impairment, they were written off as deserving of care, protection or adequate treatment. CBFJC agree with the closing remarks from Professor Vic Rayner, that "*we need those decision makers to think about social care first. It's not Cinderella. It's not the handmaiden of the NHS. It's a vital public service that's the backbone of communities. And we forgot that then and we must never do that again*" [Day 4/119:14].

Fourth - failure to prepare for the second wave and to learn lessons

93. The second wave of the pandemic saw further huge loss of life in Welsh care homes. ONS data analysing deaths across England and Wales shows that Wales had the highest proportion of Covid related deaths of care home residents in Wave 2 - at 28.8% [INQ000509882_0006].
94. It was well known that there would be a second wave of Covid-19 with the potential to be more severe than the first. The current Chief Scientific Adviser to the UK Government, Professor Dame Angela McLean, described in her witness statement to Module 2 that the September and October 2020 period was "*the worst moment of the pandemic*" [INQ000309529_0046], because, "*we could see what was coming and could not understand why the government did not act upon the science advice by introducing effective interventions*" [NQ000309529_0044], and "*We could see infection rates rising. We knew that a large portion of the population had still not been infected so were still susceptible. It was therefore inevitable that the epidemic would grow larger"* [INQ000309529_0045].
95. The monthly reporting to CIW [INQ000198645 tab 9] shows how the numbers of suspected and confirmed Covid-19 deaths in care homes in Wales fell to single figures in July and August. This 2020 summer lull provided an opportunity to take steps to prevent further significant loss of life. However, not only was this opportunity squandered, but decisions were taken that placed care home residents at increased risk, resulting in further devastating loss of life with 1,138 suspected and confirmed Covid-19 deaths in Welsh

care homes in the second wave (October 2020 to February 2021) and a peak of 460 deaths in January 2021.

96. On 25 November 2020 WG decided to intentionally delay the vaccination of care home residents, contrary to the explicit recommendation of the Joint Committee on Vaccines and Immunisation (JCVI) [INQ000493687_0023, §95]. The reason that care home residents were the first JCVI priority cohort for vaccination was because of their extreme vulnerability and because vaccination had such pronounced benefit, as explained by Professor Wei Shen Lim in his evidence [Module 4/Day 8:89/7-90/6]: "*the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age care home, we would protect one life. The same number needed to vaccinate to prevent one person from dying in a 65-year old cohort was 1,000, and of the number needed to vaccinate -- to prevent one life -- save one life in the 50-plus cohort is 8,000. So by the time we get to children and young people who have no underlying health conditions, then the number needed to vaccinate to prevent one adverse outcome -- clinical outcome, not safety outcome -- is in the many tens of thousands*".
97. The requirement for ultra-low freezer capacity for the Pfizer vaccine was known from at least 25 August 2020 [INQ000501330_0018 §67] and the failure to procure the necessary freezer storage and develop a delivery plan for care homes in the four months to December, given the known risks to life, is inexcusable. All UK nations faced this challenge, but the response of WG was by far the least effective. Vaccinations in Wales commenced on 8 December. However, by 26 January 2021 only around 67% of care home residents had received their first dose [INQ000508504]. By 16 February, at the tail end of Wave 2, this number had risen to just 82% [INQ000410143].
98. In contrast, Scotland reached this level over a month earlier on 12 January 2021 [INQ000376337] and Northern Ireland delivered vaccinations to care home residents on 8 December 2020, the first day of the programme, and by 26 February 2021, all residents and staff in their care homes had been offered a first and second dose [Day 1/166:14-24]. The WG's departure from JCVI advice was discussed in a Cabinet Office meeting on 12 January 2021 [INQ000088889] when it was noted that Wales had taken a different approach to other nations by prioritising NHS staff for the Pfizer vaccine.
99. This poor performance was accompanied by the usual spin and false statements that CBFJC has come to expect of WG. In the witness statement of Mark Drakeford to Module 4, it is stated, "*On 18 January 2021, during a BBC Radio 4's Today programme I was asked about the vaccine roll out in Wales and the suggestion that Wales had vaccinated fewer proportion to its population than other nations of the UK. I explained that there was a very marginal difference in the vaccination statistics but in any event, I explained that the supplies of the Pfizer vaccine had to last until the beginning of February*

and would not be used all at once. I explained that it would be logistically damaging to use the vaccine all in the first week and the sensible thing to do was to vaccinate over the period that we had to vaccinate, so that the system could absorb it. At no time was the Pfizer vaccine withheld. All Health Boards were received doses of Pfizer which were successfully deployed in a manner to minimise wastage, which at that time was less than 1%. I committed to vaccinating all four priority groups by the middle of February and this was achieved" [INQ000474420_0030]. This statement is incorrect in two material respects: first, the statement, "*at no time was the Pfizer vaccine withheld*" is not correct, and vaccines were deliberately withheld from care home residents by a decision of the Minister for Health and Social Care, Vaughan Gething, on 25 November 2020; second, the statement, "*I committed to vaccinating all four priority groups by the middle of February and this was achieved*" is also not correct, with only 82% of care home residents being vaccinated by 16 February 2021.

100. Given that the case fatality rate among infected unvaccinated elderly care home residents was one in three, and that vaccine effectiveness for this group against death from Covid-19 was established at between 64% and 96% for doses one and two, rising to 97.5% after dose three [INQ000544935][6], this represents yet another failure by WG to implement an essential safety measure until it was too late to avoid mass fatalities, and shows how little they learned from Wave 1.

101. Another decision that placed care home residents at increased risk was to discharge hospital patients with low level positive tests to care homes from 15 December 2020. The risk was described as low; however, there remained uncertainty. And there had been concerns about the possibility of such a reversal from as early as 3 July 2020, as described at §102 of the witness statement of Claire Sutton of the Royal College of Nursing: "*Helen Whyley wrote to Dr Andrew Goodall, Director General Health and Social Services and Chief Executive NHS Wales, after being given the opportunity to comment on the document NHS Wales Covid-19 Operating Framework - Quarter 2 (20/21) [CS/013 - INQ000525175]. The RCN was pleased that there was still a focus on older people in care homes and that their needs were being met. We felt, however, that we were missing an assurance that any older person being admitted to a care home or returning from hospital would have tested negative for Covid-19 prior to their transition.*" [INQ000587657_0027].

102. The fact that the WG was prepared to take risks with the lives of care home residents by discharging positive testing patients into care homes at a time when deaths in care homes were rising rapidly, having already suspended vaccinations, and knowing the devasting impact of infection once it entered a care home, disproves the claims of the WG

[6] Duration of vaccine effectiveness against SARS-CoV-2 infection, hospitalisation, and death in residents and staff of long-term care facilities in England (VIVALDI): a prospective cohort study' published in the Lancet in July 2022

that the most vulnerable in Wales were at the heart of their decision making.

103. CBFJC were also promised a care home investigation by Mark Drakeford during a face-to-face meeting with him at WG buildings in August 2022. He agreed that "just because it is difficult, it doesn't mean it shouldn't happen". However, no investigation was commissioned, and instead a 13-page good practice guide, 'Undertaking Factual Reviews for Residents Who Acquired COVID-19 Within the Care Home Sector'[7] was issued to care home providers in October 2023. Not only does this guidance place the onus of investigation on care home providers, but there is also no duty or requirement to conduct an investigation, meaning few, if any, will have been performed, and with no means of considering the national picture, nor the role and actions of the WG and other public bodies. When this guidance was published, CBFJC immediately wrote to WG on 26 October 2023 to complain that the First Minister had agreed to a Welsh care home investigation, and that the guidance failed to deliver on this agreement. Further, that what was required was an investigation in Wales to determine why care homes were not prepared for an airborne and asymptomatic virus, why they had so many cluster outbreaks, why PPE, oxygen and testing was unavailable, the impact of staff movement between different care home premises, and a definite account of the numbers and causes of death of those who died over the pandemic while in care homes, particularly in the absence of any inquests. The failure of WG to hold such an investigation is typical of WG in making false promises, avoiding scrutiny of their actions, and failing to seek to learn from their mistakes.

Conclusion

104. The anger felt by bereaved families in Wales is not just rooted in the loss of their loved ones, but in the neglect and indignity that they suffered, in the WG's refusal to accept their mistakes, and in the ineffectiveness of organisations tasked to protect care home residents. The WG needs to take responsibility for what went wrong so that there can be learning and improvement and so that families can begin to move on.

105. Despite challenge from organisations such as CIW and the OPCW, they were unable to effect meaningful change during the pandemic. CBFJC therefore seek a recommendation that will provide genuine independent scrutiny of the care sector in Wales allied with powers to hold those responsible for the provision of care accountable.

106. CBFJC conclude this closing statement with the words of Helen Hough, in her email to the Welsh Government on 4 May 2020, in which she stated "*I do hope, when this is over, this is all thoroughly investigated, because I and many other Managers will be stating what a diabolical shambles this is in Wales, and possibly causing many unnecessary deaths…*" [INQ000598472].

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[7] https://www.gov.wales/sites/default/files/publications/2023-10/undertaking-factual-reviews-for-residents-who-acquired-covid-19-within-the-care-home-sector.pdf

COVID 19 INQUIRY

MODULE 7: TEST, TRACE AND ISOLATE

WRITTEN CLOSING STATEMENT

OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU (CBFJ CYMRU)

Introduction

1. This closing statement is focussed on matters affecting Wales and the implementation of the Test, Trace, Protect (Wales) programme (**TTP Wales**). There were significant differences in the Test, Trace and Protect policies employed in Wales, with numerous and substantial variances in approach, resources and deployment across the four UK countries throughout the relevant period (January 2020 until February 2022).

2. The CBFJ Cymru's shared lived experience of TTP Wales was one of a chaotic system where policies were ineffective, messaging was confusing, and implementation was inconsistent, late, contradictory and at times incoherent. Decisions in Wales were often different or taken later than in the other UK countries.

3. As the Inquiry is aware, the issue of nosocomial infections and deaths is a major concern of the CBFJ Cymru, many of whose loved ones died from infection acquired in a hospital or care home setting in Wales. The delayed and chaotic nature of the Welsh Government's implementation of TTP Wales contributed significantly to these tragic circumstances.

4. The submissions of the CBFJ Cymru are set out in accordance with the topics identified in the Inquiry's List of Issues (**LoI**):
   - Decision making
   - Infrastructure and capacity
   - Key policies

List of Issues 1: Decision-making, including the engagement between UK Government and the devolved administrations in relation to TTI systems

5. At a ministerial level, the Welsh Government frequently suggested they were given insufficient warning as to UK Government policy decisions. Mr Gething told the Inquiry, "*we were finding out things as they were being announced…on the hop*" [6/126/8-15]; Mr Drakeford commented that "*inevitably there were frustrations*" [6/185/3]. The CBFJ

Cymru is concerned to ensure that such complaints are approached with caution, given the Welsh Government's desire for political point-scoring apparent in this and other Modules, and the evidence of good cooperation and collaboration between the Chief Medical Officers and Chief Scientific Advisors (referred to by the CMO for Wales, Sir Frank Atherton, as "*excellent cooperation and information sharing*" [INQ000575984_0060]).

6. That said, there is at least once instance where the lack of engagement between UK Government and the Welsh Government raises legitimate questions: the setting up of Deloitte's mass testing site in Cardiff City Football Stadium.

7. PHW said this of the mass testing centre [INQ000587250_0075-76]:

> *335. …A call took place [with Deloitte] on 1 April 2020, during which we were advised that Deloitte had set up a drive through mass sampling facility at Cardiff City Stadium and it would be ready to accept keyworkers for testing from 2 April 2020.*
> *336. This was the first time that Public Health Wales was made aware that the mass sampling centre had been established. The Welsh Government was also not aware of its establishment until this time.*
> *337. Following internal discussions, we spoke with Deloitte again on 2 April 2020 and asked them to "step down" the facility until Public Health Wales had had further conversations with the Welsh Government.*

8. Jo-Anne Daniels, Director of TTP Wales from April 2020 onwards, confirmed in her evidence to the Inquiry that the Welsh Government was indeed apparently unaware of the mass testing centre [6/82/6-9].

9. Dominic Cook was a partner in the Major Programmes Team at Deloitte. He explained that Deloitte's role was to identify and build regional testing sites (RTS), such as the one in Cardiff. It was not Deloitte's role to seek approval from or liaise with the Welsh Government; Deloitte understood that the DHSC was responsible for such matters. Deloitte did, however, liaise directly with Cardiff City Council, and indeed had signed a lease with them in order to set up the RTS in Cardiff [5/155/24-156/5].

10. It is almost inconceivable that the Welsh Government and PHW - the lead agency responsible for public health in Wales - were unaware of the setting up of the largest mass testing site in Wales. If that was indeed the case, then it points to serious

communication failures between the UK Government and the Welsh Government. More relevantly for Wales, it points to a serious communication failure within government structures within Wales: how could it have come to pass that the Welsh Government and PHW were so adrift from the decision making of Cardiff City Council on such a key public health development during the pandemic? The communication failures take on a particular significance given the Welsh Government has repeatedly sought to impress upon the Inquiry in its 'lessons learned' the virtues of small governance, and the good levels of cooperation across the different levels of government. The debacle surrounding Cardiff RTS exposes the lack of substance of such claims.

11. Whatever the cause of the failure, it was, of course, the people of Wales who suffered the consequences. The site's opening was delayed by a week at a critical time in Wave 1 of the pandemic (April 2020), whilst PHW resolved issues relating to sampling methodologies and access to testing results (which, due to a lack of integrated systems, could not be seen on patient's records) [INQ000587250_0076, §339]. These are delays which could and should have been avoided, had basic communication channels existed between Cardiff City Council and PHW/Welsh Government.

List of Issues 2: Infrastructure and capacity

12. The Inquiry will consider what systems were in place to rapidly scale up, including in relation to test development, diagnostics, and national and local tracing.

13. The CBFJ Cymru is concerned that there was a limited ability to trace in Wales, let alone an ability to scale up testing and tracing systems in Wales. Despite numerous pandemic preparedness exercises in the last two decades, the Welsh Government did nothing to build capacity in testing and tracing systems. The CBFJ Cymru set them out here as they provide important context for the failures to scale up effectively.

2003: Exercise Shipshape [Module 1 - INQ000235217]

14. Exercise Shipshape was an exercise carried out in June 2003. Its aim was to explore the contingency plan in the event of an outbreak of Severe Acute Respiratory Syndrome (SARS) in South West England and Wales. The concerns raised in Shipshape remain as relevant today as they were in 2003, as the findings on key objectives demonstrate:

> ***1. To explore the capabilities of local healthcare systems in coping with an increasing number of SARS cases.***
>
> • *There was a need to think about safety procedures and places for*

assessing patients.

- *Staffing resources would be problematical*
- *Should one hospital in the area be designated an infectious diseases receiving hospital? Should it be geared up now?*
- *There may not be adequate ITU bed capacity and protective equipment*
- *Decontamination advice will be given by hospital infection control teams who should have a policy in place - there is a trust-wide policy in place (Wales)*
- *There are health & safety issues around air conditioning units*

2. To explore control of infection guidelines, including isolation procedures and communication protocols.

- *Decontamination protocols (e.g. WHO/CDC) and all related issues to be dealt with subsequently by a taskforce*
- *Communications protocols apparently already exist between PCTs and SHAs, but were not readily apparent*
- *Guidelines may need revision, in light of exercise …*

4. To explore contact tracing arrangements and co-ordination of data communication.

- *In a non-exercise situation, contact tracing would be very time and labour intensive. Who would carry this out?*
- *Consider strengthening staff training to cover contact tracing.*
- *Who holds the operational data? There needs to be an integrated national database at Colindale to provide information for WHO, SW Epidemiology and CDSC*

5. To identify resource requirements.

- *Does NHS have capacity?*
- *There is a need for surge capacity and relief arrangements*
- *Lack of personal protective equipment (in this context includes gloves, gowns and TB- quality facemasks).*
- *Clarify PPE stocks and ensure safe storage*
- *Look at emergency department capacity*
- *Look at ICU capacity* [INQ000235217_0004].

15. The CFBJ Cymru observe that, had learning from Exercise Shipshape been implemented, Wales would have been in a far better position by the time of the Covid-19 pandemic some 17 years later. Instead, there appears to have been no

learning whatsoever. As Anna-Louise Marsh-Rees, co-leader of CBFJ Cymru, said in her evidence to the Inquiry: "*there were a number of recommendations that were made, including being able to effectively contact, trace and isolate. Clearly none of that seemed to be taken on board in subsequent years*" [1/146/12]. Indeed, such was its perceived insignificance that the final report of Exercise Shipshape was disclosed by the Welsh Government one month after the conclusion of Module 1 (and thus was not addressed by the Inquiry during the public hearings considering preparedness in Module 1).

2009: Exercise Taliesin [Module 1 - INQ000128976]

16. Exercise Taliesin took place in April 2009. The aim of *Exercise Taliesin* was to test the Pan-Wales Response Plan and influenza pandemic plans by live exercise across Wales. Exercise Taliesin exposed a number of gaps in plans which "*need to be addressed ahead of a more serious pandemic*" [INQ000128976_0013]. Of particular concern was the social care sector:

> *Social Care*
> *Although considerable progress was made in developing resilience within the social care sector during the response to swine flu further work is required to enhance the engagement with, and preparedness in, the independent care sector [INQ000128976_0014].*

17. The de-brief recorded the following under the heading, 'What Next?':

> *The completed report will be circulated to all Local Resilience Forums for them to consider the outcome and the recommendations and to translate these into appropriate actions to further develop pandemic flu planning at the LRF and organisational levels. This will compliment the lessons learnt agreed in the individual LRF de-briefs and those produced for each LRF by Gold Standard. Individual agencies will also have their own de-brief reports to draw upon in this process.*
>
> *The Wales Resilience Partnership Team will consider the recommendations which can be taken forward at an all-Wales level to help support local pandemic flu planning.*
>
> *It is likely that a more detailed review of the swine flu response will be undertaken at all levels following the end of the pandemic. This will develop further recommendations to help improve planning* [INQ000128976_0006]

18. None of this appears to have been done. The Wales Resilience Partnership Team agreed to set up the Wales pandemic flu task and finish group to consider recommendations from the 2009 swine flu pandemic. As confirmed in the oral evidence of Dr Andrew Goodall in Module 1, that group did not finish its task and the recommendations were not all fully implemented [13/95/9-10].

2013: the Pollock Review

19. A 2013 review called the Pollock review investigated why lessons were not being learned. As a result of that review, the Wales Learning and Development Group was formed, and a decision was taken to apply a Joint Organisational Learning strategy. Nothing happened.

2014 and 2016: Exercise Cygnus [Module 1 - INQ000187149]

20. Exercise Cygnus was the Welsh Government's pandemic flu exercise. The report in October 2016 'Exercise Cygnus – Wales De-Brief Report' [INQ000187149] set out a list of recommendations. Of particular note were the following:

> ***Recommendation 1*** *- All organisations were asked to review their pandemic plans regarding health countermeasures to ensure they remained robust;*
> ***Recommendation 2*** *- All organisations to ensure there is sufficient awareness within their organisations of what is held within the Welsh National Stockpile and how these would be distributed to them*
> ***Recommendation 3*** *- All organisations to review their local delivery points and antiviral collection points to ensure they remained current and to share this information with Welsh Government*
> ***Recommendation 4*** *- The Pan-Wales Response Plan should reflect the fact that Welsh Government needs to establish a Battle Rhythm early for all situation reporting to assess the impact of any emergency on the LRF areas and set out clearly and early what information is required...* [INQ000187149_0004-0007].

21. The Inquiry will recall from Module 5 that a failure to maintain adequate and in date stockpiles led to (amongst other things) inadequate supplies of PPE and a completely chaotic distribution system – such that local hospitals and care homes did not receive what they needed. The Wales Resilience Partnership Team delegated the responsibility of implementing recommendations to yet another body, the Wales Pandemic Flu Preparedness Group. However, the workstreams which were identified after Exercise

Cygnus in 2016 were not all fully implemented because the body designed to ensure implementation, the Wales Pandemic Flu Preparedness Group, did not sit after January 2018. Mr Drakeford in Module 1 explained that this was because resources were needed elsewhere due to Brexit planning. Such explanations lack substance: Wales has suffered from two decades of failures to implement recommendations from its learning exercises.

2016: Exercise Alice [INQ000001213]

22. Although Exercise Alice focused on England, it was attended by a representative of Welsh Government who, as such, would have been aware of the learning and recommendations. This is particularly relevant as the exercise examined the response to MERS-CoV. The following recommendations are of critical importance:

- *Develop a MERS-CoV serology assay procedure to include a plan for the process to scale up capacity.*
- *Produce a briefing paper on the South Korea outbreak with details on the cases and response and consider the direct application to the UK including port of entry screening.*
- *Explore the capability for contact tracing and quarantining of possible MERS-CoV cases:*
    - *Produce an options plan using extant evidence and cost benefits for quarantine versus self-isolation for a range of contact types including symptomatic, asymptomatic and high risk groups.*
    - *Develop a plan for the process of community sampling in a MERS-CoV outbreak.*
    - *Develop a live tool or system to collect data from MERS-CoV contacts.*
    - *Research, review and identify good practice for definitions for close-high risk contacts and recommend a definition for MERS-CoV.*
    - *Prepare a FAQ for MERS-CoV close/high risk contacts.*

2019: TTP scheme Llanelli

23. The Welsh health system had experience of a TTP scheme following the outbreak of a respiratory disease (tuberculosis) in Llwynhendy, Llanelli, in 2019. Mr Gething, in his evidence to the Inquiry in Module 2, described the system as follows:

> *we had a highly efficient contact tracing system and service for small to modest outbreaks. So I think I've given the example of the TB outbreak in Llwynhendy that*

took place, and actually our contact tracing system there was really good and really efficient but actually the scale of what was required – that wasn't really contemplated as a learning point that was ever brought to me after Cygnus… [Module 2 11/47/12].

24. Similarly, Mr Drakeford in his Module 2 witness statement cited the TTP-type scheme for a tuberculosis outbreak in Llanelli as evidence that Wales has a "*pre-existing infrastructure that had served the nation well*" [INQ000575983_0017, §§59-62].

25. But Mr Gething and Mr Drakeford are wrong to point to this experience as a success story. A report by PHW into the management of the TB outbreak found that there were "*serious failings*" linked to contact tracing, with the result that "*infected people were unrecognised and developed active disease, passing the infection on to others*".[1] Cases linked to the outbreak in 2010 continued to be identified in 2019.

26. The CBFJ Cymru are frustrated that exercises took place to no effect: recommendations were not implemented leaving Wales vulnerable when the pandemic arrived in 2020. In short, Wales' starting point was wholly inadequate. It had no hope of scaling up effectively.

'Scaling up' testing in laboratories in Wales

27. As was acknowledged by the Welsh Government in its evidence to the Inquiry, Wales lacked the ability to scale up test and trace and effectively. The reason given was that Wales had not anticipated test and trace on the scale required by Covid-19. This explanation exposes a lack of preparedness. However, the CFBJ Cymru is also concerned to ensure that the decision-making of the Welsh Government as to scaling up is scrutinised. In particular, the CBFJ Cymru asks whether better use should have been made of existing testing infrastructure of PHW laboratories in Wales, in the period prior to the establishment of mass testing sites.

28. Here the evidence of Sir Paul Nurse and his Dunkirk metaphor is apposite:

We needed the big ships but we had to appreciate that they would take time to be put in place and that we had to do something before they could get in place, and they would probably always be a bit slower.

[1]'Llwynhendy Tuberculosis Outbreak external review report', 2 December 2022, jointly commissioned by PHW and Hywel Dda University Health Board.

The little boats, on the other hand, such as the Crick, could produce, as I've explained, much more rapid turnover in getting the data back, and would be very essential at the beginning of a pandemic because if you don't know where the infection, is you can't actually take any ways of preventing it. So it's absolutely critical [4/12/7-18].

29. Sir Paul's evidence was that had the smaller boats - the laboratories which were directly connected to hospitals and care homes - been utilised effectively, they would have "*easily managed*" routine testing of health care workers and care home workers in the early stages of the pandemic. The effect, had this been done, would have been to protect healthcare workers and vulnerable patients alike.

…we could have scaled up to around 10,000 in a month if we'd had the money. And given what I've already said, there's nothing that special about the Crick except we were prepared to do it and to do it very quickly. That could have been rolled out, using our protocols, to 30, 40, 50, maybe more places in the rest of the UK. I'm guesstimating there, I haven't actually counted them, but I'm thinking of research universities and other research institutions.

So if you just do the simple maths there, you can see that, within a month or two, we could have had 100,000 to 200,000 tests which would be turned around every 24 hours, locally set up. And that, I think, would have been a very effective way of dealing with the early days of the pandemic [4/21/8-22].

30. PHW produced a witness statement in which they set out the testing capacity at the start of the pandemic, including 13 PHW laboratories. However, there appears to have been no consideration as to scaling up the use of these laboratories – as the Crick Institute envisaged – in the early stages. Given Wales' high rate of nosocomial infection, this would appear to have been a missed opportunity and the likely consequence of a complete failure to plan for such a scenario.

List of Issues 3: Key policies

31. This section sets out key concerns of the CBFJ Cymru in respect of the TTP Wales. The topic, in particular the testing aspect of it, lies at the heart of the CBFJ Cymru's concerns.

32. Despite numerous pandemic preparedness exercises in the last two decades (described above), the Welsh Government did nothing to build capacity in testing systems. And,

when the pandemic arrived, this unpreparedness translated to a refusal to recognise the value of testing and to ensure it was prioritised.

33. Concerns regarding different aspects of the policies are addressed below.

A. Testing

(1) Delay in recognition by the Welsh Government of the value of asymptomatic testing

34. The Inquiry has heard expert evidence about when the scientific community acknowledged asymptomatic transmission.

35. Professor Christopher Fraser, Professor of Infectious Disease Epidemiology, told the Inquiry that the evidence of asymptomatic transmission "*emerged quite clearly throughout February and March 2020*" [2/199/19-20]. And at paragraph 19 of his witness statement, he explains:

> *During February 2020, after discussions with several colleagues, it became clear that it would be useful to model TTIQ in the context of the new virus…A* ***startling difference*** *[emphasis added] that became immediately apparent from case reports was that many people appeared to be infected by asymptomatic source cases; over 70% in the case reports from China CDC. I contacted a colleague in Hong Kong to discuss this and confirm the validity of the results, which he did. We also consulted the dashboard of the Singapore ministry of health. They found that whilst many people seemed to have asymptomatic source cases, these source cases themselves became symptomatic after a few days. This proved that transmission was likely happening before people became symptomatic. Our estimates rapidly converged on about* ***50%, half of all transmissions****, [emphasis added] coming from cases that were not symptomatic at the time of transmission* [INQ000475153_0007].

36. Sir Paul Nurse, director at the Crick Institute, told the Inquiry there was "*ample evidence, actually from very early on*" of asymptomatic transfer, citing studies from China, Hong Kong, Italy, the cruise ship Diamond Princess [4/32/16-19].

37. Professor Harries (PHE and UKHSA) supported these views and told the Inquiry:

> *…asymptomatic testing and the risks were completely understood, I think, in March…at the start of April…there was a particular study in the US, in the Seattle*

care home, which gave a lot of strong evidence with very good data and denominator factors of asymptomatic transmission, and then PHE actually did what's known as the Easter 6 study…which gave us…homegrown UK figures for the first time, which were really robust…I think it was generally around April time…when the reality of the proportion of cases…of asymptomatic transmission was recognised [10/142/6-21].

38. The Seattle care home study referred to by Professor Harries is at INQ000224063. It was posted as an early release on the website of the Morbidity and Mortality Weekly Report on 27 March 2020, and formally published on 3 April 2020. The report found that once Covid-19 was introduced into a nursing facility, rapid transmission occurred, and that of the 30% of residents at a particular facility that tested positive, approximately half were asymptomatic on the day of testing.

39. The PHE Investigation of SARS-CoV-2 outbreaks in six care homes in London over the easter weekend (13-17 April 2020) found that of the 218 residents, 107 (49.1%) were SARS-COV-2 positive and of these 107 residents, 51 (47.7%) did not develop any symptoms during the two weeks before or after swabbing. 20% of the staff tested positive, of whom only approximately 20% were symptomatic [INQ000320602].

40. On 14 April 2020, the 'Go Science' advice confirmed that asymptomatic infection, "*is common and represents a large proportion of disease transmission…Intensive track-and-trace testing efforts, including of asymptomatic individuals, are thought to be core to the successful disease control efforts in South Korea, Hong Kong, and Singapore…*" [INQ000087177_0001-2].

41. This was the same date that Sir Paul Nurse and fellow scientists at the Crick wrote to Mr Hancock to urge asymptomatic testing of health care workers – a priority cohort given their potential exposure to the virus and given their proximity to vulnerable people:

> *We followed the Committee's debate on the adequacy or otherwise of testing capacity within the NHS, but were surprised that, as far as we could hear, no mention was made in that assessment, of the need to test asymptomatic or oligo-symptomatic individuals, be they health-care workers or patients. This is of great concern in view of emerging evidence that a high proportion of infections are asymptomatic, obviously entraining a high risk of transmission between and among HCW and patients…*

…Our perception is that, at present, there is reticence about doing more widespread testing of health- care workers. It will clearly be expensive and yet another challenge for hospitals that are already under pressure. Some have privately expressed their concern that making a positive diagnosis in asymptomatic health-care workers who might otherwise continue to work will deplete staffing levels at a time of need. Whilst perhaps understandable, these concerns are not productive in terms of the overall goal of controlling the epidemic. Rather it will result in recurrent problems of seeding fresh outbreaks with staff absences and the potential for infecting non-Covid patients in the health-care environment. Importantly, we consider that these concerns can only be overcome by a clear central directive from you as Minister [INQ000587060_0001].

42. Mr Hancock told the Inquiry that 14 April 2020, the date of the Go Science advice, was the date from which the UK government started making decisions on an assumption of asymptomatic transmission [8/32/23-25].

43. The following day, on 15 April 2020, the Lancet published evidence [INQ000587051] outlining the case for routine testing of healthcare workers given asymptomatic transmission. The article reported:
    - A study of asymptomatic infection on the Diamond Princess cruise ship showed 51.7% were asymptomatic at the time of testing;
    - China's National Health Commission recorded on 1 April 2020 that 78% of positive cases (in a study) were asymptomatic;
    - Healthcare worker testing could reduce in hospital transmission – 41% in Wuhan got it in hospital. At the Royal Gwent Hospital, approximately half the A&E staff tested positive;
    - There was a powerful case in support of mass testing of both symptomatic and asymptomatic healthcare workers to reduce risk of nosocomial transmission and asymptomatic testing was "*critical*" to pursuing an exit strategy [INQ000587051_0002].

44. However, Wales was much slower to take account of the serious risk of asymptomatic transmission within its decisions and policies, despite being aware of the dangers this posed to vulnerable people. For example, on 24 March 2020 in the Senedd, the former First Minister, Mark Drakeford warned, "*…most people will experience a very mild episode of this illness…The problem is that while you are asymptomatic you could be passing the virus on to somebody who is much more vulnerable*" [INQ000420992_0020].

45. On 29 March 2020, Public Health Wales advised that "*[i]f new...or existing residents do not have any symptoms...there is no value in testing for the presence of coronavirus*" [INQ000336344].

46. Mr Drakeford uses almost identical language in the Welsh Senedd:
    a. On 29 April 2020, Mr Drakeford told the Senedd when asked about routine testing in care homes, that "*the clinical evidence tells us that there is* ***no value*** *in doing so.*"
    b. On 6 May 2020, he similarly told the Senedd that he had not seen "*any evidence*" that asymptomatic testing had any "*clinical value*" in homes where there was no coronavirus in circulation.

47. Explanations for these bizarre statements were offered by Mr Gething - who referred to the "*cut and thrust*" of the debating chamber [6/166/16] – an unconvincing explanation given Mr Drakeford was clearly following the party line developed earlier in March, and then doubled down on the claim on 6 May. Dr Howe also attempted to defend Mr Drakeford by pointing out that the second statement in the Senedd was conditional on there being no coronavirus in circulation [9/129/9-17]. However, CBFJ Cymru submit that the views of Peter Halligan, Chief Scientific Advisor for Wales as expressed by Robert Hoyle (Head of Science for the Welsh Government Office for Science) are to be preferred. He wondered what "*the rationale, evidence and advice*" [PHT000000073_0046] was behind Mr Drakeford's comments.

48. However one interprets these comments, one thing is clear: there was no change to the Welsh Government's baseline flawed assumption until mid-May.

49. The Welsh Government point to the "*new*" SAGE advice of 12 May 2020 [INQ000587349_0048, §167] that extensive asymptomatic testing in care homes was *crucial*, to justify their delay in not introducing partial routine testing in care homes until 16 May 2020 (not expanded to all care homes until 15 June 2020). But this entirely misses the point – this was not new knowledge or advice at all as clearly demonstrated above.

50. The Welsh Government had the scientific evidence. Whatever the claimed difficulties in communication at Ministerial level, there was a high degree of collaboration between the UK CMOs, Chief Scientific Advisers and public health agencies. Thus, Wales would have been aware of the evidence in the scientific community, known by Professor Fraser, Sir Paul Nurse, Professor Harries, as referred to above, and in which respect CBFJ Cymru

asks the Inquiry to find that the scientific evidence was sufficiently strong as at 3 April 2020 (the date of publication of the Seattle care home study) to require government decisions and policy to be premised from this date on the assumption of very significant levels of asymptomatic transmission.

51. Further, the SAGE meeting minutes (at which the Chief Scientific Adviser for Wales was represented) demonstrate that the issue of asymptomatic transmission (and the related need for testing) was recognised throughout April and was not "new" advice on 12 May 2020, as claimed by the Welsh Government:
    a. 14 April SAGE 25 (the day of the GO Science report advising of the evidence of widespread asymptomatic transmission and that symptomatic-only based screening will miss cases) – at §§8-11: warning of significant transmission in hospitals and care homes and the need for increased testing in these settings.
    b. 16 April SAGE 26 – at §§3, 31, and 33: "*Testing is an important part of controlling transmissions in hospitals and care homes*"; SAGE advises that the recommendations of the Nosocomial Working Group to reduce nosocomial spread should be adopted immediately in a coordinated fashion across all 4 nations, and *"SAGE advised that longer-term thinking on using separate sites for confirmed Covid-19 patients should be considered - as well as repeat testing of patients testing negative*".
    c. 23 April SAGE 28 – §§10-14: testing to commence of asymptomatic patients and staff and a testing strategy to reduce the spread in care homes is required.
    d. 28 April SAGE 29 – §9: the proportion of cases acquired through nosocomial transmission may be increasing again. SAGE noted work underway to test new admissions to hospital as well as asymptomatic staff.
    e. 30 April 2020 SAGE 30 – §§11-15: variation in levels of nosocomial transmission, with a rebound and persistent rise in some Trusts…significant transmission in care homes…a substantial surveillance system is needed to reduce transmission…A recent NHS study suggests a positive test rate among asymptomatic healthcare workers of 5-6%.
    f. 5 May 2020 SAGE 33 - §2: "*SAGE advises that based on current data, focus should be maintained on reducing transmission in health and care settings. Urgent action should be taken in establishments where relevant measures are not already in place, in line with previous advice (such as avoiding movement of patients or staff between establishments, separating people as far as practical, and testing extensively)*". This is the day before Mr Drakeford states in the Senedd (for the second time) that there was no clinical value in routine testing.

g. 7 May 2020 SAGE 34 - §§1 and 14 "*SAGE reiterated its advice that there should be extensive testing of healthcare workers including asymptomatic workers*" and SAGE reiterated the importance of addressing the epidemic in the healthcare and care home sectors and reiterated its advice that there should be extensive testing of healthcare workers including asymptomatic workers as well as the application of other measures previously advised. SAGE participants offered to provide advice to the healthcare worker testing programme if required.

52. During the Module 7 hearings, the Welsh Government maintained that they did not delay the introduction of asymptomatic testing in care homes and that they responded promptly to the 'new' advice of SAGE on 12 May 2020. However, the evidence exposes this for what it is: an after the event corporate position statement that seeks to avoid criticism for delaying testing rather than a factually accurate account of what happened that would provide much needed answers for the families of the bereaved.

53. CBFJ Cymru believes that the most likely explanations for the failure of the Welsh Government to introduce routine testing sooner are because of a lack of testing capacity and concerns that such testing would require large numbers of staff to isolate leading to staff shortages (for both of which the Welsh Government bore responsibility). Blaming scientific uncertainty was a convenient means of avoiding this responsibility.

54. In the final analysis, and for reasons still yet to be fully explained, Wales was slow to acknowledge the risks of asymptomatic transmission and the value of asymptomatic testing. Whatever the reason, the delay undoubtedly calls into question the view expressed by Mr Drakeford in oral evidence that in Wales:

> *we planned first and then we announced. And sometimes that makes us look like we were doing things later than was happening elsewhere, but I believe that our method was more effective* [6/208/9-13].

55. What was more effective, the CBFJ Cymru asks, about repeated delays in the implementation of essential safety measures which endangered the lives of so many of the most vulnerable people in Wales? Further, the Welsh Government was not planning how to implement routine testing in care homes before making that announcement in May 2020; it was denying that there was a clinical value to it at all.

56. The CBFJ Cymru made reference in its opening to the question posed by CTI in Module 2B, namely whether the Welsh Government's position on asymptomatic testing was a

position that could have been genuinely or sensibly held. And the CBFJ Cymru suggest that it is abundantly clear from the evidence that it was neither

(2) Delays and failures in testing regime for priority testing groups

57. On 24 April 2020, the Welsh Government published its Covid 19 exit strategy: 'Leading Wales out of the coronavirus pandemic: a framework for recovery' [INQ000083221]. The strategy indicated that in order to understand the level of infection in Wales, the Welsh Government was stepping up its testing capacity and capability. However, the strategy contained no detail on how such testing capacity and capability would be accelerated. When asked about these deficiencies in the Senedd on 29 April 2020, Mr Drakeford re-iterated Wales' focus on testing only key workers. And, in the same session, he added that to draw "*any value from testing non-symptomatic people, you'd have to do it every day*", which would "*take away*" tests from others that need the testing. Despite all the evidence given in Module 7, the reason for the Welsh Government's reluctance to test and their lack of focus on testing remains unclear.

58. The deficiencies of the Covid 19 exit policy underpinned wholly inadequate and delayed testing decisions, the most notable of which are as follows:
    a. The failure to test hospital patients upon discharge to care homes
    b. Delays to routine testing within care homes
    c. Delays to/insufficient routine testing among health care workers
    d. Delays to/insufficient routine testing of patients in hospital

a. The failure to test hospital patients upon discharge to care homes

59. Over 1,000 patients were discharged from hospital into care homes in Wales, prior to the introduction of testing on discharge on 29 April 2020. This practice seeded infections into vulnerable communities, and was exacerbated by the lack of PPE, testing, and effective treatment and equipment available in care homes. It continued notwithstanding concerns as to the vulnerability of care home residents raised in the Senedd on 3 March 2020 [INQ000321248] and reiterated by Care Inspectorate Wales on 8 April 2020 [INQ000198288 and INQ000396510].

60. Despite these concerns, and knowing the risks of asymptomatic transmission, the Welsh Government refused to introduce testing on discharge to care homes on 8 April 2020 because of insufficient testing capacity [INQ000551798_0089]. CBFJ Cymru disputes the legitimacy of this justification because the number of untested discharges to care

homes per day in Wales at this time was just 10.5 [INQ000271757_0008] and while testing capacity was not large (1000 tests per day as at 9 April rising to 1800 by 20 April [INQ000312371_0002 and INQ000253584]) there was sufficient from which to prioritise this small number of discharges having regard to the serious danger of asymptomatic introduction of Covid-19 into a vulnerable care home community.

61. Further, the introduction of testing on discharge in Wales was some two weeks after testing on discharge was introduced in England (on 16 April 2020), and this same delayed and reactionary process is repeated throughout the pandemic.

62. The Welsh Government issued an apology in its opening submissions in Module 7: "*there ought not to have been a delay between the 15 April 2020, when the risk came to the fore…and the ultimate publication of guidance on 29 April 2020*" [1/124/7-11]. However, no explanation for the delay has been provided.

63. Incredibly, this practice of transferring Covid-19 positive patients into care homes persisted into wave 2 in Wales, with patients judged to be 'non-infectious' being discharged from hospital without a negative test from December 2020 [INQ000262400]. While recommending the change in policy, the TAG statement acknowledged that *"there remains uncertainty around the period of infectivity for individuals infected with SARS-CoV-2"* [INQ000227902_0004]. Concerns about this policy were raised with Welsh Government via email by the Older People's Commissioner for Wales, who wrote that *"this indicates that some risk would remain that individuals could still be infectious in this situation and could post a risk of an infection spreading in a care home or other setting"* [INQ000185049_0001].

64. This change in policy was implemented at a time when the number of deaths involving Covid-19 in care homes was increasing - notifications to CIW of deaths in adult care homes increased from 21 in October 2020, to 217 in December 2020, and nearly doubled in January 2021 to 417 [Module 6 - INQ000198645]. Given the huge increase in deaths in care homes during wave 1, this decision demonstrates reckless disregard to learn lessons, to recognise the risks for vulnerable care home residents, and to avoid the huge loss of life experienced in the second wave.

b. Delays to routine testing within care homes

65. The failure of the Welsh Government to provide routine testing in care homes is a matter of very great concern for the CBFJ Cymru and encapsulates everything that was

wrong about the approach of the Welsh Government to the pandemic, including a failure to take a precautionary approach to the risks of asymptomatic and aerosol transmission; inaccurate claims that testing had no value; numerous changes of policy; a lack of transparency; and delays in implementation, including in comparison with other UK countries.

66. Over this period, a member of the CBFJ Cymru, who owned and ran a care home in Wales, campaigned extensively for routine testing because of the risks of asymptomatic transmission. It was glaringly obvious to her as someone working on the front line that routine testing was essential. As elderly and vulnerable care home residents were falling ill and dying within 48 hours of becoming symptomatic, she pressed for further testing. PHW, who were supposed to provide the test, were often unable to provide testing quickly enough in the period between the onset of symptoms and death [INQ000587321_0010]. Her increasingly desperate messages to the Welsh Government in April and May 2020, included the warning:

> *I do not know how long it is going to be before relatives of the deceased speak to one another and realise they are not going to be treated with the same importance as England (less than 9 miles from here)…Relatives are assuming these tests are being carried out as they see it on their national news…and [would] be horrified to learn that the Welsh Government has decided it [i.e. testing] is not important enough* [Module 6 - INQ000598470_0002].

67. On 16 May 2020 the Welsh Government announced routine testing in care homes. No satisfactory explanation has been provided for why it took until 16 May 2020 to announce routine testing for residents of large care homes, and why it took until 15 to announce routine testing of residents in care homes of all sizes, as well as care home workers (as stated above the risks and grave consequences of not doing so were known from at least 3 April 2020).

68. Lack of testing capacity is an unsatisfactory explanation: it points to a chronic failure to plan and an inability to scale up effectively. It also leaves unexplained the consistent under-use of testing capacity in Wales throughout April, May and June 2020, as set out in the table below:

Date	Testing capacity[2]	Actual usage	Percentage	Reference
09.04.2020	1,000	1,254	125%	INQ000312371_002
20.04.2020	1,800	1,033	57%	INQ000253584
05.05.2020	2,100	743	35%	INQ000530780
02.06.2020	9,500	2,400	25%	INQ000087992_012

69. Various explanations have been advanced to explain under-use of tests in Wales. The Welsh Government sought to suggest that under-use was a necessary feature of the system: "*you can't run the [testing] system at full throttle every single day*" [6/182/10-11]. A further explanation was that some tests needed to be held back for "*some emergency in the Covid context where you will need some spare tests*" [6/182/7-8]. Finally, it was suggested that it was necessary to set aside some tests for non-Covid matters [6/182/18-19].

70. These ineffectual explanations do not properly justify why it was that in early May 2020, when infections and deaths from Covid-19 were at a peak, 65% of PHW testing capacity in Wales was left unutilised. To suggest that keeping tests for 'some emergency' or 'non-Covid' matter should take precedence over the lives of vulnerable care home residents is derisory and an affront to the many members of CBFJ Cymru whose family members died in Welsh care homes during this time.

71. It reveals a complete failure to take a precautionary approach to protecting the lives of older people in Wales. Mr Drakeford told the Inquiry he believed that the Welsh Government "*did take a precautionary approach. And then the question is: could we have taken a more precautionary approach? And I don't think the evidence would have justified us in doing so*" [6/203/15-18]. The CBFJ Cymru disagree and submit that there is ample evidence before the Inquiry that routine testing of all staff and residents within care homes should have become Welsh Government policy much sooner.

c. Delays to/insufficient routine testing of healthcare workers

72. Experts recognised early on that routine testing of healthcare workers was, to quote Sir Paul Nurse, "*absolutely clear that was essential*" [4/40/25]. It would help prevent nosocomial infection and would maintain, rather than deplete, workforce levels. The

[2] Refers to daily testing capacity within PHW laboratories and in due course the Welsh share of testing capacity within Lighthouse Laboratories.

Inquiry heard similar evidence from Professor Kloer in Module 3: testing limited viral spread [Module 3 – INQ000475209_0005, §33].

73. In Wales, routine testing of healthcare workers was not announced until 4 December 2020 (following the usual pattern of two to three weeks after England, which announced on 16 November 2020). However, many Health Boards in Wales did not implement routine testing of healthcare workers until March 2021. Some were even later: Hywel Dda University Health Board took a phased approach to routine testing which commenced in February and was completed by July 2021 (albeit the majority of staff were tested by the end of March 2021) [Professor Kloer; Module 3 30/162/12-164/18]. Furthermore, whilst the policy mandated testing twice weekly, testing took place every five days.

74. Of course, lateral flow tests only became widely available in November 2020, but that does not explain (i) why greater use of existing capacity was not used to test before 14 December 2020, and (ii) more importantly, why even when lateral tests were available, routine testing took until March 2021 to implement, after wave two. Mr Gething told the Inquiry he "*was pretty frustrated at the lack of pace in the use of the tests*" [6/161/12-13]. He went on to say:

> *…having a phased rollout through areas is fine, but for it to take that long, isn't fine…when I make a ministerial choice, I expect the system to deliver on that choice…if it's not happening, then I can't do anything about it if I don't know, and I don't think Welsh Government officials were really properly sighted on it…* [6/162/14-23].

75. At no stage, did Mr Gething offer any explanation as to why it took until March 2021 for the routine testing of healthcare workers to be implemented, preferring instead to attribute delays to the local health boards. Nor did he accept any responsibility for the complete breakdown in implementing Welsh Government policy decisions, or the related communication failures between Welsh Government and other public bodies.

d. Delays to/insufficient routine testing of patients in hospital

76. The Welsh Government announced testing of all patients on admission to hospitals on 3 June 2020 and again on 15 July 2020. Reminders had to be sent out to NHS Wales directors in September 2020 because the policy was not being implemented properly. And it was not until 28 January 2021 that the Welsh Government introduced repeat testing of patients every five days.

77. But problems in testing and repeat testing endured, notwithstanding reminders and notwithstanding new policies. The Audit Wales report of March 2021, 'Test, Trace and Protect, an overview of progress to date' reported:

> *1.18 PHW figures show that compared to the first wave of the pandemic, hospitals have been testing proportionately more patients on admission, increasing from 24% in the first wave to 54% in October, but there remains conservable room for improvement…Once tested on admission however there has been no regular testing during a patient's hospital stay unless patients have developed symptoms…*
>
> *1.19 …It has been clear that once an in-hospital outbreak occurs, spread of COVID-19 as a result of hospital transmission has…resulted in very poor outcomes for patients…* [INQ000214244_0017].

78. The report concluded that nosocomial infections could have been reduced by more effective testing, including more frequent testing during a patient's stay. This much known is by the CBFJ Cymru as many of their loved ones fell victim to basic testing failures. More frustratingly, witnesses offered no explanation for such failures. Along with the failure in routine testing of healthcare workers, blame was simply laid at the door of the health boards.

79. There has been no attempt to explain why this was so. And of course, without insights or reflections, there is no hope for lessons learned.

80. In Wales, routine testing was introduced on admission with five days repeat testing for asymptomatic patients from 28 January 2021 [INQ000227387]. This was in contrast to the approach in England where repeat testing was every three days. However, many patients were not tested in accordance with that policy, waiting many more days for repeat testing. Some reported loved ones being sent home following an outbreak in the ward, in order that the ward could be cleaned, but without being tested; they died in their homes.

81. The experiences of the families provide valuable context for such policies. Their experiences demonstrate clearly the chaotic testing in hospitals throughout the pandemic:

    a. October 2020: Anna-Louise Marsh-Rees, co-leader of the CBFJ Cymru, recalls how her father was admitted to hospital for a routine operation and was tested for Covid on admittance. He was negative. He was moved six times in eight days, ending up in a ward in which 21 patients and 13 staff had Covid. He was

discharged without being tested again (hospital staff told him they only tested those being discharged to care homes). Neither he nor any of his family members were advised to take a test. He deteriorated immediately once home and had to be re-admitted to hospital one week later. He was tested on admittance and tested positive for Covid-19. Tragically, he died three days later.

b. December 2020: another member recalls how her loved one was admitted to hospital in December 2020 (with a non-Covid related issue) and his health rapidly deteriorated. However, he was not tested for Covid until his fourth day following admission. Instead, he underwent a series of intrusive and invasive tests during that period before being tested for Covid, which returned as positive. He was discharged, without a further test, and died.

c. December 2020-January 2021: Jane recalls how the GP told her he suspected both her parents had Covid. Her father went to hospital first, was tested on admittance and the test was positive. He was admitted to a corridor, before being moved to a cubicle. Tragically he died. Jane's mother went to hospital a few days later. She had a test on admittance and the test was negative. Jane was told her mother was fit for discharge and could be collected. Jane insisted she have three clear tests before she returned home. A few days later, she had a second test, which was positive, and she was admitted to a Covid ward. However, in the intervening period, she was permitted to wander freely in the (non-Covid) wards, without a mask, interacting with patients and no doubt (completely unknowingly) contributing to the spread of the infection within the hospital.

d. February 2021: Theresa (who appeared on the 'Impact' video in Module 1) recalls how her mother was admitted to hospital for a non-Covid related matter. She was tested whilst in her ward, and the test result was negative. She was not tested until 10 days later, despite the policy to test every five days, and despite the ward (with patients in it) being closed due to a Covid outbreak. Her second test was positive. Tragically, she died a few days later having tested positive for Covid.

(3) Restricting access to testing to 'the cardinal three'

82. The CBFJ Cymru is also aware that testing criteria in Wales was limited to the three cardinal symptoms – fever, continuous cough and loss of smell. However, many people experienced a wider range of symptoms, such as headaches, sore throat, fatigue, nausea, diarrhoea etc. The Welsh Government's failure to acknowledge this broader range of symptoms in testing criteria, even as late as March 2021, would have led to countless instances of symptomatic people continuing to spread the virus. Exhibited to

the Module 3 witness statement of the CBFJ Cymru's co-lead, Anna-Louise Marsh-Rees, is a letter that her father (as a Shielding Patient) received from the CMO for Wales, Sir Frank Atherton, in October 2020 that states:

> *You will need to self-isolate if you develop one of the following symptoms, a new continuous cough, a high temperature, loss of or change to sense of smell or taste. You should also apply for a test online if you develop one of these symptoms.* [INQ000327639_0005]

83. Dr Howe acknowledged the possibility that this decision meant that people with the virus remained untested [9/117/4-9].

84. Like so many aspects of the testing regime, the decision making here demonstrates the very opposite of a precautionary approach in action. The Inquiry has heard from Professor Tim Spector that as early as March 2020, he and his colleagues had evidence that "*in the elderly aged over 75, acute confusion could be the only presenting symptom*" [INQ000575990_0004, §8].

85. Yet, despite Ministerial Advice dated 23 March 2021 that the "*current 3 cardinal symptoms together have a combined specificity of approximately 50%*" and that symptom criteria for public ***access*** to a test should be broadened [INQ000116616_0012-0013], the recommendation to the Minister was that "*national messaging should remain focussed on the 3 primary symptoms*" [INQ000116616_0001]. Undoubtedly this resulted in healthcare workers and patients, and care home workers and residents, experiencing symptoms but not realising that they should be tested and inadvertently transmitting the virus.

(4) Failure to meet testing targets

86. The ability to set clear targets for testing is plainly an important feature of any effective policy. However, the CBFJ Cymru are concerned at what appears to be a lack of communication between the Welsh Government and PHW regarding testing targets in Wales. The Minister for Health and Social Services, Vaughan Gething, had communicated in March 2020 the target of increasing capacity to 9,000 daily tests in Wales by the end of April 2020. However, when questioned by the Senedd Health and Social Care Committee in May 2020, Dr Tracey Cooper (the Chief Executive of PHW) insisted that this was not a target she was familiar with. The CBFJ Cymru question how

this can be the case, when PHW had briefed Mr Gething on 20 March 2020 of this capacity target of 9,000 tests [INQ000195536].

B. Tracing

87. The tracing programme was inadequate in Wales. It completely overlooked care homes, and there was no attempt to trace anyone that had been in contact with an infected patient or healthcare worker during a cluster outbreak. The proximity app, introduced presumably because of its anticipated value, had very low take-up levels.

88. A key concern held by the CBFJ Cymru is that contact tracing in Wales was halted in March 2020 and did not restart until June 2020, almost two months after the peak of the first wave in Wales on 12 April 2020.

89. In relation to paper-based tracing, restaurants and the hospitality industry in Wales regularly required customers to complete paper-based forms for the purposes of contact tracing, and the CBFJ Cymru wished to understand if this largely paper-based data was provided to, and used by, the Welsh Government or PHW in the tracing programme, and if so, how this data was shared and used. The CBFJ Cymru sought clarity on the voluntary nature of such systems and is concerned that the inefficiency and ineffectiveness of such schemes allowed the virus to spread further and contribute to the overwhelming second wave of Covid-19 in Wales.

90. In relation to the NHSX 'app', the CBFJ Cymru wished to know how this was used in Wales, how many people in Wales used the app, how the data was used and what procedures were in place following a close contact alert. In particular, the CBFJ Cymru raised three issues relating to NHSX that were of particular concern:
    a. what consideration was given to the population in Wales who did not have smart phones or may have had challenges due to technological literacy, and limited internet access, such as with the older population and those living in rural areas?
    b. why was the NHSX unfit for purpose in the healthcare setting? The CBFJ Cymru understands healthcare workers were notified when there was a Covid patient nearby, even if separated by a wall. Such features meant healthcare workers turned off the NHSX app. This would have defeated the purpose of contact tracing within the app, and would have put many lives at risk, particularly vulnerable people in healthcare settings.

c. why was there a significantly lower uptake of the app in Wales than in England, as demonstrated by the map prepared by Professor Fraser [INQ000475153_0027, §74 (figure 1b)].

91. Despite three weeks of evidence, these important questions in relation to Wales remain unanswered.

Conclusion – the Whole System

92. In connection with an initial report by Independent SAGE in early May 2020 on 'how can testing and tracing be successfully achieved', Professor McKee asked, "*Can we take a whole systems approach to understanding tracking and tracing?*" [2/52/20-21]. Professor Fraser told the Inquiry, "*[t]he whole system is important*" [2/203/18] and Professor Buchan's evidence was:

> *…testing is more than a test. It is a whole system. It is a system embedded in a community that requires tracing around people who test positive, the understanding of why that tracing is important, effective means of isolation, including support for people in isolation, to consider social and economic factors. That is, it's a whole-community, whole-system approach* [3/6/1-8].

93. This view was shared by SAGE as seen in the minutes from SAGE 53 on 27 August 2020:

> *The effectiveness of mass testing will depend on several factors including the proportion of the population tested; the frequency of testing; the ability of a test to identify true positives and negatives; the speed of results; and adherence to isolation. It is important to recognise that testing is one part of a system leading to isolation of infectious individuals and the whole system needs to work in order to achieve the desired aim (which would be to identify as many infectious people as possible and isolate them from contacts during the infectious period)* [INQ000061561_0003, §18].

94. The CBFJ Cymru support these views. There is a crucial need for a system that is comprehensive, mutually reinforcing, and capable of being implemented quickly when needed – not one that takes months to establish while infections rage, putting lives at unnecessary risk.

SURGICAL MATERIAL TESTING LABORATORY

TEST REPORT

Testing of 3M FFP3 respirators

Report No: 20/6058/1

Report Date: Thursday 27th February, 2020

Authors:
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Testing of 3M FFP3 respirators
Report No: 20/6058/1

Louise Barry

Thursday 27th February, 2020

1 Name & Address of Client/Requesting Authority

Procurement Services,
NHS Wales Shared Services Partnership,
4th Floor,
Companies House,
Crown Way,
Cardiff, CF14 3UB.

2 Introduction

SMTL were requested by NHS Wales Shared Services Partnership - Procurement Services to test samples of 3M FFP3 respirator masks which were past their expiry date. The testing was based on testing undertaken in 2009 for similarly expired masks.

For comparison purposes, laboratory physical testing was also performed on masks currently available from Welsh Procurement stores. These masks were within their shelf life date but are of a different design to the expired stock samples.

3 Test Products/Samples for this project

Table 1: Samples

Manufacturer	Product Name	Description	Catalogue Number	Batch/Lot Number	Quantity	Date received	SMTL Sample ID
3M	Particulate Respirator	EN 149:2009 FFP3 R D	8833	725908	80	31/01/2020	62386
3M	Health Care Respirator	EN 149:2001 FFP3	1873V	NOT SUPPLIED	90	31/01/2020	62387
3M	Health Care Respirator	EN 149:2001 +A1:2009 FFP3 R D	1895V+	M1C192970241	20	04/02/2020	62389
3M	Aura Health Care Respirator	EN 149:2001 +A1:2009 FFP3 NR D	1863+	C191501	20	04/02/2020	62390
3M	Aura Health Care Respirator	EN 149:2001 +A1:2009 FFP3 NR D	9332+	C193241	20	04/02/2020	62391

NOTE:

- The test results in this report relate only to the test sample(s) analysed.
- The Manufacturer, Product Name, Description, Catalogue & Batch Numbers were provided by the client.

Images of the two expired masks can be seen in Figures 1 and 2.

Figure 1: Mask model: 1873V

Figure 2: Mask model: 8833

3.1 Departures/Abnormalities of Sample Condition

- SID 62386 had an expiry date of 13/10/2016
- SID 62387 had an expiry date of 01/08/2019

4 Date of Testing

3rd - 12th February 2020

5 Location of Testing

- EN 143 NaCl filter penetration testing was subcontracted to and performed at S.F.P. Services Ltd., Unit 12, Sea Vixen Ind. Est., Wilverly Rd., Christchurch, BH23 3RU.
- All other testing was performed at SMTL premises.

6 Testing Details

6.1 Filtration Efficiency (FE)

EN 149:2001[1] (the European Standard for respiratory protective devices) classifies masks as FFP1, FFP2 and FFP3 depending on their filtration efficiency. Two FE tests are specified in the standard - one for sodium chloride penetration, the other for paraffin oil. EN 143:2000[2] defines the test method used in EN 149:2001[1].

In 2009, SMTL discussed the most appropriate test programme with 3M, the HSE and Dr Tony Wilkes (Dept. of Anaesthetic Maintenance, UHW). It was agreed that the paraffin oil test was less relevant to the NHS requirements, and that the NaCl test would be sufficient to assess whether the filter media still performed to specification.

6.2 Face-Fit testing

The HSE also stated (in 2009), in a telephone conversation, that in their view some form of fit testing was necessary to demonstrate that the mask seal, straps and filter medium were performing adequately, and mentioned RPA (Respiratory Protective Assessment) as a possible provider of the test. RPA undertook the testing in 2009, and therefore SMTL contacted RPA again for this project in 2020.

RPA confirmed that they were able to perform fit testing on healthy volunteers at SMTL using both 8833 and 1873V masks using a twin channel particle counter which measures ambient particulate levels in the room and inside the mask, and calculates an arbitrary 'Fit Factor' level based on the reduction in particle counts inside the mask.

The test machine used is a TSI Portacount. The test method is a quantitative method (as opposed to the qualitative methods used with taste detection). Ten SMTL staff volunteered to take part in this test but one member of staff was unable to complete the test.

During the test, the user wears the mask which is monitored continuously, and performs a series of exercises as recommended by the HSE in monograph 81 of HSE 282/28[3], which includes periods of normal breathing, deep breathing, head turning, speaking and bending from the waist.

The aim of this exercise was to compare mask performance on individuals whom the mask fitted as opposed to assessing the individual volunteer's goodness of fit.

6.3 Physical testing of component parts

The final set of tests were designed to check if the physical properties of component parts of the mask such as the elastic straps and the foam seal were comparable to similar "in date" masks.

6.3.1 Force at Break of the straps

Using an Instron Tensometer, Force at Break (FAB) tests were performed on samples of straps from the masks using a 100mm gauge length and a cross-head speed of 500mm/min.

6.3.2 Force at Break of the foam

Using an Instron Tensometer, Force at Break (FAB) tests were performed on cut dumbbells of foam from the masks using a gauge length of 40mm and a cross-head speed of 500mm/min.

6.3.3 Elasticity

Using an Instron tensometer, the force at 50% extension was measured on samples of straps from the masks using a gauge length of 100mm and a cross-head speed of 500mm/min.

6.4 Standards relevant to the test method

- BS EN 143:2000 - Respiratory protective devices. Particle filters. Requirements, testing, marking[2].
- BS EN 149:2001 - Respiratory protective devices. Filtering half masks to protect against particles. Requirements, testing, marking[1].
- HSE OC 282/28 - Fit testing of respiratory protective equipment facepieces[3].

6.5 Testing Conditions

No special conditions required

6.6 Deviations/exclusions from, and additions to standard methods

None.

6.7 Sampling Details

All samples were selected and supplied by the client.

6.8 Sample Preparation

As per the sub-contractors requirements or the relevant SMTL Test Method.

7 Results

7.1 Filtration Efficiency

The results of the Sodium Chloride testing for the two mask types are presented in Tables 2 and 3 respectively.

EN 149 requires FFP3 masks to show a penetration level of ≤ 1%. As can been seen from Tables 2 and 3 both masks exceeded this performance requirement.

Table 2: Results of Sodium Chloride Efficiency 8833 (SID 62386)

Sample No	Penetration NaCl (%)
1	0.081
2	0.32
3	0.175
4	0.231
5	0.049
6	0.119
7	0.012
8	0.049
9	0.088
10	0.112
Mean	0.124
Std. Dev.	0.09

Table 3: Results of Sodium Chloride Efficiency 1873V (SID 62387)

Sample No	Penetration NaCl (%)
1	0.018
2	0.027
3	0.028
4	0.023
5	0.023
6	0.039
7	0.247
8	0.029
9	0.032
10	0.024
Mean	0.049
Std. Dev.	0.07

7.2 Face-Fit Testing

The Portacount test kit results give a 'Fit Factor' as described in HSE 282/28, and FFP3 half masks are required to show fit factors of ≥ 100. The results of the testing are presented in Table 4.

Table 4: Results of Face-Fit Testing

ID No	Model No.	Fit Factor	Pass/Fail
11/11/74	8833	0	FAIL
11/11/74	1873V	177	PASS
12/11/87	8833	0	FAIL
12/11/87	1873V	0	FAIL
15/09/91	8833	2739	PASS
15/09/91	1873V	0	FAIL
07/03/74	8833	2030	PASS
07/03/74	1873V	0	FAIL
26/10/83	8833	3811	PASS
26/10/83	1873V	0	FAIL
11/13/82	8833	0	FAIL
11/13/82	1873V	0	FAIL
22/08/95	8833	4843	PASS
22/08/95	1873V	221	PASS
18/03/60	8833	2854	PASS
18/03/60	1873V	794	PASS
09/04/62	8833	1788	PASS
09/04/62	1873V	0	FAIL

- Model number 8833 is SID 62836
- Model number 1873V is SID 62837
- Two of the test subjects had pass results for both masks.
- Mask 8833 had six passes.
- Mask 1873V had three passes.
- Where users failed to achieve a pass on the test, it was possible to achieve a pass result after testing was complete by holding the mask in place on the face of the test subjects. These results are not documented in the table above.

7.3 Physical Testing

The results tables below give test data both from masks which are past their expiry date and which are within their expiry date. Tables related to masks which are past their expiry date include the expiration information in the table caption.

The samples which were tested for physical properties, including their expiry date, are listed in Table 5:

Table 5: List of samples undergoing physical testing

Cat No.	Sample ID	Expiry Date
8833	62386	13/10/2016
1873V	62387	01/08/2019
1895V+	62389	27/10/2024
1863+	62390	30/05/2024
9332+	62391	20/11/2024

7.3.1 Force at Break - Straps

The force at break testing for the elastic straps of the masks are presented in Tables 6 - 10.

Table 6: Results of Force At Break Testing - Straps 8833 (SID 62386) - expired 13/10/2016

Sample No	Force At Break (N)
1	109.07
2	109.81
3	104.46
4	103.00
5	104.66
Mean	106.20
Std. Dev.	3.0

Table 7: Results of Force At Break Testing - Straps 1873V (SID 62387) - expired 01/08/2019

Sample No	Force At Break (N)
1	15.24
2	15.17
3	14.74
4	15.48
5	14.39
Mean	15.00
Std. Dev.	0.4

Table 8: Results of Force At Break Testing - Straps 1895V+ (SID 62389)

Sample No	Force At Break (N)
1	394.40
2	406.12
3	400.82
4	406.93
5	412.86
Mean	404.23
Std. Dev.	7.0

Table 9: Results of Force At Break Testing - Straps 1863+ (SID 62390)

Sample No	Force At Break (N)
1	17.46
2	14.42
3	14.65
4	14.05
5	12.99
Mean	14.71
Std. Dev.	1.7

Table 10: Results of Force At Break Testing - Straps 9332+ (SID 62391)

Sample No	Force At Break (N)
1	17.19
2	16.83
3	16.09
4	17.05
5	16.00
Mean	16.63
Std. Dev.	0.6

7.3.2 Force at Break - Foam

Due to the size of the foam on the masks it was only possible to test model 8833. The results of this testing are presented in Table 11.

Table 11: Results of Force At Break Testing - Foam 8833 (SID 62386) - expired 13/10/2016

Sample No	Force At Break (N)
1	5.04
2	4.81
3	4.21
4	4.68
5	4.27
Mean	4.60
Std. Dev.	0.4

7.3.3 Force at 50% extension - straps

The results of the force required to achieve 50% extension testing are presented in Tables 12 - 16.

Table 12: Results of Force At 50% Extension Testing - Straps 8833 (SID 62386) - expired 13/10/2016

Sample No	Force At Extension (N)
1	2.51
2	2.60
3	2.70
4	2.64
5	2.56
Mean	2.60
Std. Dev.	0.1

Table 13: Results of Force At 50% Extension Testing - Straps 1873V (SID 62387) - expired 01/08/2019

Sample No	Force At Extension (N)
1	1.46
2	1.42
3	1.42
4	1.41
5	1.53
Mean	1.45
Std. Dev.	0.0

Table 14: Results of Force At 50% Extension Testing - Straps 1895V+ (SID 62389)

Sample No	Force At Extension (N)
1	5.91
2	5.43
3	5.25
4	5.48
5	5.56
Mean	5.53
Std. Dev.	0.2

Table 15: Results of Force At 50% Extension Testing - Straps 1863+ (SID 62390)

Sample No	Force At Extension (N)
1	1.69
2	1.92
3	1.96
4	1.91
5	1.65
Mean	1.83
Std. Dev.	0.1

Table 16: Results of Force At 50% Extension Testing - Straps 9332+ (SID 62391)

Sample No	Force At Break (N)
1	1.70
2	1.78
3	1.40
4	1.73
5	1.67
Mean	1.66
Std. Dev.	0.1

8 Discussion

8.1 Fit Test results

The masks tested were available in a single size and were not easily adjustable. During testing, the tester from RPA observed that for some members of staff, especially female staff, the mask was too big for their face and did not fit well. It is therefore unsurprising that these subjects failed the fit test.

Although not documented, it was the opinion of the accredited RPA tester that the masks passed the testing when fitted to appropriately sized volunteers. Where the masks fitted a member of staff correctly, the results of both mask designs were very good, although the 1873V mask usually underperformed the 8833 mask.

Our opinion is that the failures of the masks were probably due to the sizing of the mask rather than the performance of the mask.

8.2 Physical test results

As the mask models are different from those tested in 2009, (out of date versus in-date testing of Cat 8835) and also from in-date stock from stores, the conclusions we can draw from the physical testing is necessarily limited.

8.2.1 Foam

For the foam testing, we have historical data from the masks tested in 2009 (Cat 8835) and current data from the Cat 8833 expired mask. The mean FAB results are:

- 8833 (expired) - 4.6N
- 8835 (from 2009) - 5.1N

Although it is unknown if we are comparing identical foams, the difference between the two products is approximately 10%. If we assume that the foams were identical in the first place, our opinion is that whilst these results may indicate minor loss of tensile strength of the foam, a variation of 10% in physical properties in elastic products is not unusual in our experience. On balance we do not think that the foam has degraded substantially

8.2.2 Head straps

Mask models 1873V (expired), 1863+ and 9332+ all use a head-strap which is similar to a rubber band. Our opinion is that this is more likely to degrade over time compared to the elastic straps used on 8833 and 1895V.

The mean Force at Break (FAB) for the 'rubber band' style head straps are:

- 1873V (expired) - 15.0N
- 1863+ (in date) - 14.7N
- 9332+ (in date) - 16.6N

As the expired stock 1873V has a very similar FAB profile to the similar in-date stock, our opinion is that there is no evidence that the head strap on the expired product has degraded noticeably compared to the in-date product.

The Force at 50% extension for the 'rubber band' style head straps are:

- 1873V (expired) - 1.45N
- 1863+ (in date) - 1.83N
- 9332+ (in date) - 1.66N

Again, although it is unknown if we are comparing identical straps, the difference between the expired product and the two in-date products is approximately 20% for the 1863+ and 10% for the 9332+.

Similarly to the foam, our opinion is that whilst these results demonstrate differences between the expired masks and the in-date masks, the in-date masks have a 10% difference between them, and a variation of 10% in the physical properties in elastic products is not unusual in our experience.

On balance we do not think that the elastic band style straps have degraded substantially

The straps on the 8833 mask and the 1895V+ mask are substantially different and we cannot comment on the differences between the results. It is, however, worth noting that the FAB and Force at 50% extension is much higher for the 8833 expired mask than the rubber band style in-date masks.

8.3 Summary

The results above show that:

1. The filter material has been shown to pass the performance requirement for both expired masks;
2. The fit tests demonstrate that both expired masks can pass the performance requirement if it is the appropriate size for the member of staff and fits well;
3. There was no visible degradation of the mask materials (mask, head strap and foam where used);
4. The physical tests (FAB and extension tests) do not show significant variation from similar in-date product.

Therefore it seems reasonable to conclude that if a member of staff has been successfully fit-tested with the same model of mask previously then these masks should perform appropriately on that subject.

9 Authorisation

Approved and signed electronically. Please see last page of this document.

Pete Phillips, Director, SMTL.

References

[1] CEN. *BS EN 149:2001 - Respiratory protective devices. Filtering half masks to protect against particles. Requirements, testing, marking.*

[2] CEN. *BS EN 143:2000 - Respiratory protective devices. Particle filters. Requirements, testing, marking.*

[3] HSE. *Fit testing of respiratory protective equipment facepieces.* [OC 282/28].

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Agenda Item 7.1

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