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