

**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 Rules¹ 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

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

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 pandemic²² 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 uncharted 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 countries²⁹ 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 literature³¹ 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.

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 Inquiry³³), 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 guidance⁵⁶.

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 Frank 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 Frank 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 updated⁶⁰ and *draft* plans were drawn in some areas⁶¹. 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 Wales⁷² 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.

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

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 control⁷⁹, 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.

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.

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 2022¹¹⁸ 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 they 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

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 Letwin¹³⁴ 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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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 UK¹. 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 system². 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 advance⁴. 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 outcome⁵. 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 faster⁹. 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 2020¹¹, 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 points¹². 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 Johnson¹⁴, 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 growing¹⁵ 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 heard¹⁶, 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 asymptotically 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 statement²⁰. 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 care³⁴, 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 each³⁵. 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 environment³⁹) 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 respirators⁴⁴. 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 Noakes⁴⁸, 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 earlier⁵⁰.

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 clear⁵¹. 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 particular⁵².

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 communication⁵⁴.
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 approach⁵⁵.

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 necessary⁶². 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 only⁶³.

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 report⁶⁴.

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 Henderson⁶⁵ 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 Johnson 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

12 JANUARY 2024

BETHAN HARRIS

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**CLOSING STATEMENT ON BEHALF OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU
(‘CBFJ CYMRU’) - MODULE 2B**

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,

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 CMO⁶). 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 meetings¹¹. 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. Drakeford¹⁸ 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: he 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.

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 2020⁴⁰. 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 2020⁴¹. 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 2020⁴². 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 COBR⁴³. 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.

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 rugby⁴⁵ 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 pandemic⁴⁶. 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.⁴⁸The 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 conference⁶³ 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 2020⁶⁷ 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/coverings⁷⁴ which was then firmed up in the updated consensus statement on face coverings on 23 July 2020⁷⁵ 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 BBC⁹⁴ 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 homes¹⁰¹. 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 this¹⁰⁵. 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-term¹⁰⁶ 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 break¹⁰⁷. 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 2020¹⁰⁸, 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;

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 them¹⁰⁹;
- 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 2020¹¹⁰. 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 call¹¹¹. 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 sense¹¹². 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 2020¹¹³, again at COBR on 12 October 2020¹¹⁴, and again at a HMT call on 14 October 2020¹¹⁵, 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.

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 2020¹²¹, 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 Morgan¹²⁷ 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 Cymru 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 in¹²⁹; 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 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 (O 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 testing¹. It is understood that Eluned Morgan had earlier told Radio Wales Drive that the delay was occasioned by the need for a strategy². 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 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 wholesale 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 wholesale 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 an 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.

**CRAIG COURT
HARDING EVANS
SOLICITORS**

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20 DECEMBER 2024