

Covid-19 Bereaved Families for Justice Cymru
**Written closing statement for Module 4 of the UK COVID-19 Inquiry – vaccines and
therapeutics**

Introduction

1. A priority of the Covid-19 Bereaved Families for Justice Cymru group (the group) is to scrutinise whether the Welsh Government discharged its duty to protect the lives of people in Wales. This closing statement identifies key concerns of the group in relation to this duty, and is focussed on the delivery of vaccinations in the first few months of the programme to the most vulnerable people in Wales.
2. The group submits that when considering these issues, it is important to recall just what a devastating period this was, with care homes in Wales experiencing 465 Covid-19 related deaths of residents in January 2021 alone, and at times as many as 20 deaths a day.
3. Time was of the essence for many vulnerable people in Wales, as powerfully described by the group's co-lead, Sam Smith-Higgins, who told the Inquiry in her oral evidence [Day 2-15.01.25/115:21-117:22] about her fears for her 73-year-old father, who was admitted to hospital in early January 2021 for cancer related treatment, and was immune suppressed and vulnerable. Ms Smith-Higgins made efforts to secure a vaccine for her father prior to his admission but was told this wasn't possible. Tragically, just three weeks after being admitted to hospital, he died from a Covid-19 infection acquired in hospital.
4. A major concern of the group was the decision of the Welsh Government to intentionally delay and stagger the provision of vaccines to the most vulnerable cohorts, as set out from paragraphs 6 to 20 below. And this decision was all the more indefensible because of the appalling level of nosocomial infections within Welsh hospitals and care homes over the period of the delay (during which vulnerable people ought to have been prioritised), as demonstrated by the "Update on COVID-19 Nosocomial Transmission Group and current priorities" (INQ000227307) from February 2021, including the following statements and data:

"Nosocomial transmission of COVID-19 is unfortunately widespread in health boards/ Velindre Trust across Wales. Hospital transmission of COVID-19 has

been a major safety and quality concern for all NHS organisations since the start of the pandemic.” (INQ000227307/1).

“PHW data from 14/2/21 shows that 1002 patients were in Welsh hospitals with a positive COVID-19 test, and 529 of these (53%) were classified as hospital onset.” (INQ000227307/2).

“...notifications to CIW of confirmed cases in staff or residents in care homes were higher during the second wave of the pandemic. Notifications of confirmed cases peaked in the week ending on 11 January 2021” (INQ000227307/3).

5. Regrettably, the position in Wales has not improved, with data published by Public Health Wales showing as of 09 February 2025, some 83% of inpatient Covid-19 cases in Wales were the result of hospital-acquired infection.

The decision of the Welsh Government to deliberately slow the rate of vaccine delivery and its failure to vaccinate in accordance with Joint Committee on Vaccination and Immunisation (JCVI) priority cohorts

6. The JCVI advised that those living in residential care homes for older adults were at a high risk of exposure to infection and at higher clinical risk of severe disease and mortality, and that given the increased risk of outbreaks, morbidity and mortality in these closed settings, they were at very high risk, and should be the highest priority for vaccination. Accordingly, they were designated as cohort 1 within the priority groups.
7. However, the Welsh Government did not follow this advice, and Vaughan Gething, the former Minister for Health and Social Services decided on 25 November 2020 that the Pfizer vaccine would not be used in care homes for the first 4 weeks of delivery (paragraph 95 of the witness statement of Vaughan Gething [INQ000493687/23]).
8. This decision was taken following Ministerial Advice to the Minister for Health and Social Services (copied to the First Minister, at that time Mark Drakeford) [INQ000361639], that included the following information:

12. Given the constraints around transportation of the Pfizer vaccine to care homes described in paragraphs 5 to 8, it is recommended that the vaccine is not used in care homes for the first 4 weeks of delivery.

...

17. The incidence and spread of coronavirus in Wales and the UK as a whole is an ongoing risk to public health. A written statement on the 17 November

confirmed that while there will be limited supplies of this vaccine at first, it will be offered to those at highest risk and that priority for initial distribution of any new vaccine will be determined in accordance with advice from the Joint Committee on Vaccination and immunisation. Care home staff and residents are in Cohort 1...

9. On 18 January 2021, the former First Minister, Mark Drakeford, made a public statement in response to criticisms that the Welsh Government was behind other UK nations, and explained that, "*The sensible thing to do is to use the vaccine you've got over the period that you've got it for so that your system can absorb it, they can go on working, that you don't have people standing around with nothing to do*". [INQ000381306/2]

10. In the witness statement of Mr Drakeford to the Inquiry [INQ000474420/30] this public statement is explained as follows:

"On 18 January 2021, during a BBC Radio 4's Today programme I was asked about the vaccine roll out in Wales and the suggestion that Wales had vaccinated fewer proportion to its population than other nations of the UK. I explained that there was a very marginal difference in the vaccination statistics but in any event, I explained that the supplies of the Pfizer vaccine had to last until the beginning of February and would not be used all at once. I explained that it would be logistically damaging to use the vaccine all in the first week and the sensible thing to do was to vaccinate over the period that we had to vaccinate, so that the system could absorb it. At no time was the Pfizer vaccine withheld. All Health Boards were received doses of Pfizer which were successfully deployed in a manner to minimise wastage, which at that time was less than 1%. I committed to vaccinating all four priority groups by the middle of February and this was achieved."

11. This statement is incorrect in two material respects:

- a. First, the statement, "*at no time was the Pfizer vaccine withheld*" is not correct. It was in fact deliberately withheld from care home residents by a decision of the Minister for Health and Social Care, Vaughan Gething, on 25 November 2020.

b. Second, the statement, “*I committed to vaccinating all four priority groups by the middle of February and this was achieved*” is also not correct. As set out below at paragraphs 14 and 15, by 10 February 2021, only 78% of the first priority cohort (care home residents) had been vaccinated, which rose to only 82% by 16 February 2021.

12. Further it was well known that Wales was pursuing a different approach from other UK countries, with staggered delivery, and that it was not following the advice of JCVI on priority cohorts, as can be seen from the Cabinet Office Meeting minutes of 12 January 2021 [INQ000088889], that read:

“... 300,000 doses had been delivered to Wales, but short of 90,000 had been used so far. The press had picked up that this was down to the Welsh Government. It would be useful to have regular publication of how many vaccines had been delivered. The Welsh Government's approach was slightly different to other nations' as it had prioritised NHS staff for the Pfizer vaccine.”

13. While vaccinations in Wales commenced on 8 December 2020, by 26 January 2021 only 67% of care home residents had been vaccinated (confirmed in an oral statement of the Welsh Government by Vaughan Gething on this date [INQ0004928860]).

14. This rose to 78-79% by 10 February 2021 (as set out in the minutes of a meeting of the Four Nation Senior Responsible Owners for the Vaccination Programmes from that date, contained within an email of 12 February 2021 [INQ000412273]).

15. By 16 February 2021, well over two months after vaccination commenced, only 82% of care home residents in Wales had been vaccinated (as set out in the Welsh Government's Vaccinations Update [INQ000410143]). Whilst at first blush this might seem a high proportion, in fact it was significantly below some of the other Phase 1 priority cohorts in Wales (such as those aged 70 and over).

16. Further, the update of 16 February 2021 also demonstrates (through the graph at INQ000410143/2 with the yellow line denoting care home residents) that progress in vaccinating care home residents in Wales during February 2021 had almost flatlined.

17. The anger and confusion at the decisions of the Welsh Government to delay the vaccination of vulnerable people was reflected in the oral evidence of Ms Smith-

Higgins, on behalf of the group, on 15 January 2025, as follows [Day 2-15.01.25/116:6-19]:

“the vaccinations had started coming out on 8 December, and I was a carer for an 85-year old, my mother, so I expected her to be vaccinated relatively soon, but as December went through, I was tweeting like mad everybody, MPs, MSs, head of NHS, saying: What is going on? Why hasn't my mother been vaccinated? And it soon became apparent that actually, in Wales, they were focusing on the healthcare workers and not aged or the most vulnerable. By 11 January, Cardiff and Vale health board tweeted that up to date, up to 11 January, they had vaccinated 12,300 people, of which 69 were in care homes and only 75 were over 80.”

18. The group wishes to make clear that they take no issue with the prioritisation of frontline healthcare workers, as advised by the JCVI, but this was not what happened in Wales, with significant numbers of administrative staff vaccinated before the vulnerable. Ms Smith-Higgins refers in her witness statement [INQ000413805/5] to one such example: a relative in her 50s, with no underlying health conditions, who worked in an administrative department of one of the Welsh Health Boards, and who received her vaccination in December 2020.

19. The concern and anger about this issue was also amplified by the history of neglect of care homes in Wales during the pandemic. This was epitomised by the evidence of Mark Drakeford in Module 2B, when he told the Inquiry in March 2024 that, *“There is no single register of where every care home in Wales is located”* [M2B/Day 11-13.03.24/211:15-16], which begs the question, how was vaccination progress being managed and monitored among this most vulnerable priority group in Wales, when the Welsh Government didn't even know of their existence?

20. The group asks that the Inquiry carefully considers the circumstances in which the vaccination of priority cohorts was deliberately delayed and staggered in Wales, and highlights the following further evidential features and concerns:

- a. Despite holding the position of Senior Responsible Owner for the Vaccination Programme in Wales since June 2020, these issues are not addressed within the witness statement of Dr Gillian Richardson [INQ000501330], who was the sole Welsh witness to give oral evidence

during the Inquiry hearings, and despite the Ministerial Advice of 24 November 2020 being cleared by Dr Richardson [INQ000361639/1).

- b. The decision on 25 November 2020 not to vaccinate people in care homes was taken because of concerns about the refrigeration requirements of the Pfizer vaccine. However, these concerns had been known since at least 25 August 2020 and contingencies should have been developed and put in place by the Welsh Government. Paragraph 67 of the witness statement of Dr Gillian Richardson states [INQ000501330/18]:

"...on 25 August 2020, it was recorded that there was a significant risk of insufficient freezer storage being available to store a vaccine requiring a temperature of -70 degrees centigrade, should such a vaccine receive regulatory approval."

- c. The risks to care home residents were not negligible – they were the highest priority cohort as made clear in the advice of the JCVI (above at paragraph 6) because they were at very high risk. In this context, it is unthinkable that their vaccinations should have been intentionally delayed for want of a logistical solution that other UK countries were able to deploy.
- d. To further emphasise how important it was to adhere to the JCVI priority cohorts, the evidence of Professor Wei Shen Lim at the Inquiry's hearings [Day 8-23.01.25/89:7-90:6] was that,

"the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age care home, we would protect one life. The same number needed to vaccinate to prevent one person from dying in a 65-year old cohort was 1,000, and of the number needed to vaccinate -- to prevent one life -- save one life in the 50-plus cohort is 8,000. So by the time we get to children and young people who have no underlying health conditions, then the number needed to vaccinate to prevent one adverse outcome - - clinical outcome, not safety outcome -- is in the many tens of thousands."

- e. This also brings into question the policy of the Welsh Government to move to next priority cohorts when only 50% of a higher cohort had been vaccinated. As set out at paragraph 262 of the witness statement of Dr Gillian Richardson [INQ00050130/57]:

“Wales also permitted commencing issuing invitations to the next JCVI ordered priority cohort group when at least 50% of the cohort above had been invited, this capturing those willing to attend as swiftly as possible and enabling the mass vaccination clinics to be used to maximal efficiency.”

The group suggests that it is this same, misguided approach, that saw NHS back-office staff vaccinated before the vulnerable and asks the Inquiry to consider the extent to which volume of vaccinations (for statistical and presentation purposes) was pursued over safety.

- f. In the same vein, the group notes the absence of meaningful challenge and scrutiny of government within Wales, an example of which is the largely uncritical report of Audit Wales on the rollout of the vaccination programme in Wales from June 2021 [INQ000066528]. This report inaccurately finds that the Welsh Government adopted the JCVI prioritisation guidance [INQ000066528/4], makes the doubtful claim (see paragraphs 29 to 33 below) that the Vaccination Strategy for Wales set out the expectations for prioritisation and delivery of the vaccine [INQ000066528/9], and makes no mention of the decisions to delay vaccinations in care homes, and to stagger vaccination of other vulnerable groups. The fulsome praise of the Welsh Government by Audit Wales is set out in detail at paragraphs 147-151 of the witness statement of Dr Gillian Richardson [INQ000501330/35].
- g. The Welsh Government has complained within the Inquiry proceedings (at paragraphs 83 and 84 of the witness statement of Dr Gillian Richardson [INQ000501330/22] and elsewhere) that Wales should have received a higher number of vaccinations, because while vaccinations were allocated according to the Barnett formula (based on Wales having 4.72% of the UK population in 2019 [INQ000396131]), the population of Wales was older and had greater healthcare needs than the wider UK population, and therefore required a higher percentage of supply for the priority cohorts. The group made the point during its oral closing statement on 30 January 2025, that it considered this complaint to be politicking by the Welsh Government, and that the governments of Northern Ireland and Scotland expressed no such concerns. The group further notes that the position of the Welsh Government on the Barnett formula is inconsistent with its policy of delaying and staggering the provision of vaccines to the most vulnerable groups.

- h. The group wishes to know how many deaths could have been prevented if the Welsh Government had not delayed the vaccination of vulnerable groups between December 2020 and February 2021.

Over reliance on a small number of mass vaccination centres despite the geographical and demographic challenges of Wales.

21. The group is also concerned at the decision in Wales to heavily rely on delivery through larger vaccination centres. This decision is particularly difficult to understand given the geography of Wales with many rural and remote communities, and the demographic of Wales, which as explained by Dr Richardson in her witness statement, is an older population with greater healthcare needs than in other parts of the UK.

22. The group's co-lead, Sam Smith-Higgins, told the Inquiry in her oral evidence to the Inquiry [Day 2-15.01.25/121:17-122:7], that the mass vaccination centres in Wales covered huge geographical areas, requiring lengthy journeys by car, or for those without a car, lengthy journeys involving several buses. She told the Inquiry:

“for people who have been shielding for months and months and months, to suddenly have to take an hour-and-a-half journey within the same health board to then stand outside for an hour-and-a-half queuing to get into a sports centre, it wasn't the best thought out”.

23. The group would like to know why the Welsh Government used this model - a person to vaccine model, rather than vaccine to person model - when it would so obviously disadvantage those who were vulnerable and/or could not travel.

24. The group believes that trusted healthcare professionals, such as GPs and community pharmacists, who are embedded within communities and easily accessible, were insufficiently utilised by the Welsh Government in the delivery of vaccines compared with other UK countries. Most people prefer to access their community based primary healthcare services such as GP practices and community pharmacies for vaccination, and these services also play an important role in overcoming barriers to vaccination within their communities. The group believes that this was a missed opportunity by the Welsh Government.

25. The Oxford AstraZeneca vaccine became available at the beginning of January 2021 and was widely used in Wales from this time, as can be seen from a Wales Covid-19 Vaccination Programme Daily Situation report from 29 January 2021 [INQ000505456]. This Daily Situation Report records that some 138,000 AstraZeneca vaccines had been delivered by the end of January 2021.

26. The Ministerial Statement of the former Minister for Health and Social Care, Vaughan Gething, made on 4 January 2021, described the AstraZeneca vaccine as a “gamechanger” [INQ000388300]. The statement said as follows:

“Members will be aware of the widely reported benefits of this latest vaccine - it is cheaper and supply will be more plentiful. However, crucially, it presents significantly fewer logistical challenges than the Pfizer/BioNTech vaccine, with storage at normal fridge temperatures. As NHS capacity continues to build over the coming weeks, we will be able to get the vaccine to where it is needed in every part of Wales. Much more flexible and mobile deployment models will be activated. Every care home will be within reach and this priority group will be a key focus for the NHS over the coming weeks.”

27. The group believes that the difficulties of storing and transporting the Pfizer vaccine, while real, are too often relied upon to explain away poor performance or justify poor decisions; for example, the overreliance on mass vaccination centres and the delays in vaccinating vulnerable people.

28. Given the widespread availability of the AstraZeneca vaccine, in the quantities described in paragraph 25 above, the failure to vaccinate a care home population of approximately 16,000 residents, constituting the most vulnerable people in society, by mid-February 2021, is a striking failure.

Strategies and milestones

29. The group’s experience of the Welsh Government is that it is strong on rhetoric and weak on delivery, and they submit that this was also a feature of the delivery of the vaccination programme.

30. The Vaccination Strategy for Wales [INQ000410079] was published on 11 January 2021, and included three key milestones, the first of which was:

“Milestone 1 – by mid February – cohorts 1-4. Subject to supply, our aim is to offer vaccination to all care home residents and staff, frontline health and social care staff, those 70 years of age and over, and clinically extremely vulnerable individuals.”

31. In respect of this milestone, paragraph 153 of the witness statement of Vaughan Gething [INQ000493687/37] states:

“By 12 February 2021 the first milestone in the Vaccination strategy for Wales had been achieved with the vaccine having been offered to all those in the priority groups 1-4. Wales was the first of the four UK nations to reach this key milestone.”

32. There are many things wrong with using such a meaningless metric as the number of invitations issued, including:

- a. at the date of this ‘achievement’, only 78-79% of care home residents in Wales had actually received their first dose of the vaccine.
- b. despite claiming, *“Wales was the first of the four UK nations to reach this key milestone”*, its performance in fact lagged behind other nations, with England having vaccinated 93% of care home residents by 14 February 2021 [INQ000421393/2].
- c. measuring achievement in such a superficial way takes no account of the difficulties experienced by the many who did not receive their invitation, or who received an invitation but experienced difficulties booking and travelling to an appointment, or, as in the case of many care home residents, those who were still waiting for their vaccination to be administered at the point the Welsh Government announced the milestone had been met.

33. However, its lack of substance is best illustrated by the experience of Sam Smith-Higgins. As she said in her witness statement [INQ000413805/5], an invitation was sent to her father one week after his death, no doubt an invitation which contributed to the achievement of the milestone announced by the Welsh Government.

Other concerns

34. There were also problems with communications, including invitation letters for first and second doses being sent in an identical form which caused confusion, and concerns about the clarity of the invitations issued, which used English and Welsh language interchangeably over several pages of information, making it difficult to understand.
35. In respect of unpaid carers, the group notes the oral evidence of Dr Richardson [Day 10-28.01.25/96:7-15], that unpaid carers in Wales were able to self-certify in order to be vaccinated. However, this was not the personal experience of Ms Smith-Higgins, [INQ000413805/10] who is an unpaid carer for her mother, and it is also at odds with the Audit Wales report which states [INQ000066528/15], "*There have also been challenges identifying unpaid carers who have previously not been recorded on any system.*" It is also contrary to the evidence from the chair of the JCVI, Professor Wei Shen Lim, that in a mass vaccination programme, the main means of asking people to attend for vaccination should not be self-identification [Day 8-23.01.25/108:10-12].

Conclusion

36. In conclusion, the group asks the Inquiry to consider and, where appropriate, determine the following issues and concerns:
- a. Why vaccinations in Wales were intentionally delayed for vulnerable groups and whether these decisions led to avoidable injury and death, particularly having regard to the evidence of Professor Wei Shen Lim that the vaccination of 20 people who are resident in an old age care home, would protect one life.
 - b. Why the Welsh Government failed to follow the JCVI prioritisation cohorts, including the delay and staggering of the first four cohorts, including the widespread vaccination outside of the prioritisation cohorts (e.g., NHS administrative staff), and the policy of proceeding to vaccinate the next priority cohort while only 50% of a higher priority cohort had been vaccinated (again, with regard to the evidence of Professor Wei Shen Lim on the importance of vaccinating the most vulnerable first).
 - c. Whether the justification provided within the Ministerial Advice of 24 November 2020, and subsequent decision of Vaughan Gething on 25 November 2020, that in respect of the obligation of the Welsh Government to take preventative operational measures to safeguard the lives of Welsh citizens, the decision to delay the vaccination of people in care homes was justifiable [INQ000361639/5-6]), having regard to the knowledge from at

least August 2020 of the refrigeration requirements of the Pfizer vaccine, the evidence heard by the Inquiry that the vaccination of 20 care home residents would protect one life, and the high level of Covid-19 related deaths of some 465 care home residents in Wales in January 2021 (see paragraph 2 above).

- d. Whether there was an overreliance in Wales on mass vaccination centres at the expense of more local services.

37. Finally, in respect of the use of WhatsApp messages by the Welsh Government, the group submits that it is abundantly clear from information disclosed in Module 4, that this medium was in widespread use for operational and decision-making purposes. For example, the WhatsApp messages between the Senior Responsible Owners of the Vaccination programmes in each of the UK countries [INQ000477804] demonstrate the effective collaboration and working relationship of this group, over 49 pages and approximately 1,500 messages.

38. Similarly, the former Minister for Health and Social Services, Vaughan Gething, was part of a Ministerial WhatsApp group with Matt Hancock and other Ministerial counterparts [INQ000095819].

39. For present purposes the group simply restates its position, namely that:

- a. The claims of the Welsh Government that WhatsApp messages were not used to conduct official government business are clearly unsustainable.
- b. Such messages over the period of the pandemic are relevant to the Inquiry's Terms of Reference.
- c. Members of the Welsh Government deliberately and systematically destroyed these messages to avoid public scrutiny, including by the Inquiry.

13 January 2025

COVID 19 INQUIRY
MODULE 5:
PPE AND PROCUREMENT

WRITTEN CLOSING STATEMENT
OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU

INTRODUCTION

- 1) From 3 to 27 March 2025, the Inquiry heard evidence on 'Procurement and distribution of key healthcare equipment and supplies' (Module 5). Of the 48 witnesses who attended to give evidence, just four gave evidence on issues specific to Wales: Alan Brace, Andrew Slade, Jonathan Irvine and Richard Davis. Their evidence lasted just over 4 hours. CBFJ Cymru was allocated a total of 40 minutes to question them. Of course, the evidence of some of the remaining 38 witnesses touched on the devolved administrations. But not in any detail. And CBFJC was permitted questions of just two of the 38 - Rosemary Gallagher (RCN) and Matt Hancock - for a total of just 10 minutes. Crucially, and notwithstanding the requests of CBFJ Cymru, at no stage did the Inquiry hear from the former First Minister, the Rt Hon Mark Drakeford, nor Mr Vaughan Gething, the Minister for Health and Social Care in Wales over the majority of the relevant period (Jan 2020-May 2021) who had ultimate responsibility to ensure healthcare workers and the people of Wales had the PPE and healthcare equipment they needed.

- 2) In such circumstances, it is inevitable that gaps remain in the Inquiry's understanding of the issues faced in Wales with respect to procurement and distribution of PPE and other key healthcare equipment. That gaps remain in the Inquiry's understanding is not a criticism of the Chair: in the time available, there could be no realistic hope of unpacking the nature and extent of the failures in Wales. But the point nevertheless remains: if there is at best only a partial understanding of failures in Wales, how can the CBFJ Cymru, their members, and the people of Wales more widely, have any confidence the Welsh Government will reflect on its failures and learn lessons for the future?

- 3) The issue of 'lessons learned' and recommendations are addressed in more detail at the end of these closing submissions. In these introductory remarks, we note the CBFJ

Cymru's concerns as to recommendations and lessons learned. The signs are ominous for Wales. The evidence of the Welsh witnesses – both orally and in writing – appears to reflect the belief among those in positions of responsibility in Wales that the roots of their problems lie beyond the Welsh borders, either in Westminster or further afield. The CBFJ Cymru are concerned that there has been little reflection, let alone constructive criticism, of what went wrong in Wales.

- 4) The Inquiry should not be taken in by statements that Wales did not experience the same problems as England. Such statements have the regrettable appearance of self-congratulation. Nor should it be taken in by statements extolling the virtues of small governance. Such statements have the regrettable appearance of idealism: in reality, as we have seen, “small” does not necessarily translate to good, effective and efficient governance.

- 5) Against that background, some (not all) of the most problematic issues – and problematic gaps in understanding – are addressed below in these closing submissions.
 - a) Pandemic stockpiles
 - b) PPE and equipment in hospitals
 - c) PPE and equipment in care homes
 - d) Ventilators, oxygen and CPAP (other equipment)
 - e) IPC Guidance on FFP3 masks
 - f) Lessons learned
 - g) Conclusion

PANDEMIC STOCKPILES

Introduction

- 6) After some introductory remarks, this section on Wales' 'pandemic stockpile' covers:
 - a) The failure to implement the recommendations of exercises
 - b) Extent of the deficiencies: comparisons with the other UK nations
 - c) Addressing the deficiencies: Just-In-Time contracts and re-testing of FFP3 masks
 - d) Reasons for deficiencies in the Wales' stockpile
 - e) Conclusion

- 7) The Inquiry will be considering whether the stockpiles of key healthcare equipment and supplies were adequate to respond to the Covid-19 pandemic [LoI 1 §§1-3].
- 8) The Wales stockpile was not adequate to respond to the Covid 19 pandemic.
- 9) The Welsh Government maintained a stockpile in collaboration with the other UK nations and in accordance (primarily) with the Pandemic Influenza Preparedness Programme (PIPP) prepared in 2011. This meant it maintained a range of medical countermeasures and consumables, such as FFP3 respirators, surgical masks, eye protection, gloves etc. In addition to the stockpile, Wales also had UK wide contracts in place for additional stock to take the PIPP to 15 weeks of supply if required (the 'Just-In-Time' contracts).
- 10) It is important to note at the outset that the stockpile was the responsibility of the Welsh Government. Witnesses who gave evidence to the Inquiry appeared to show worrying confusion over this important point. Mr Brace (Welsh Government) suggested it was the responsibility of the NHS Wales Shared Services Partnership ("NWSSP") to ensure stock was monitored and fit for purpose [Brace; 6/180/17]. In other respects, he suggested it was the responsibility of the UK Government: the "plan for the PIPP stockpile was the responsibility of the UK government" [Brace; 6/191/13]; when the stockpile was down to 4 weeks, his "biggest concern was about getting clarity and assurance from the UK government they could fulfil their obligations under the emergency plan, and that proved exceptionally difficult..." [Brace; 6/191/1-8]. By contrast, Mr Irvine, director of procurement at NWSSP, understood that the stockpile was the responsibility of the Welsh Government [Irvine; 14/109/10-14/111/8]. This is consistent with the evidence of Mr Hancock, who reminded the Inquiry when asked specifically about the responsibility for the Welsh stockpile, that health was a devolved matter and the stockpile was accordingly the responsibility of the Welsh Government [Hancock;11/145/13].
- 11) The Wales stockpile was seriously deficient in the following ways:
 - a) The quantities of stock held were woefully inadequate to withstand a pandemic.
 - b) The stockpile had not been maintained and significant quantities of the equipment held within the stockpile was out of date, particularly FFP3 respirators.
 - c) The plan to supplement the stockpile through Just-in-Time contracts was flawed, and these arrangements collapsed in the face of global competition,

which the CBFJ Cymru submits was entirely predictable and ought to have been foreseen.

The failure to implement the recommendations of exercises

12) Between 14 and 20 October 2014, the Welsh Government conducted a pandemic flu exercise, Exercise Cygnus, and in October 2016 produced a report, “Exercise Cygnus – Wales De-Brief Report” [INQ000187149_0001].¹ It is to be noted that NWSSP had been in operation for some years by this stage (since 2011).

13) This report contains the following objectives, observations and recommendations:

- a) “The workshop considered what countermeasures would be made available from the national stockpile and the mechanisms for distribution across the NHS in Wales and the mechanisms for local distribution across the NHS in Wales. The morning session...raised awareness of the consumables, antivirals and antibiotics held in the national stockpile. In the afternoon, delegates had the opportunity to work through the Cygnus scenario and were able to explore the national and local arrangements for each of the countermeasures...It was acknowledged that once a pandemic is threatened, the operational details to secure effective and efficient distribution across Wales would be quickly put into place.” [INQ000187149_0003]
- b) Objectives for the day included:
 - i) “To explain why particular products are held within the national stockpile”; and
 - ii) To explain the National planning arrangements for storage and deployment.” [INQ000187149_0003]
- c) Recommendation 2 - “All organisations to ensure there is sufficient awareness within their organisations of what is held within the Welsh National Stockpile and how these would be distributed to them.” [INQ000187149_0004]

14) Despite this focus in Exercise Cygnus on the Welsh National Stockpile and the awareness of its importance, much of the stock of FFP3 respirators held within the stockpile had expired. The stocktake of the Welsh National Stockpile performed in February 2020 [INQ000300270] records that out of a total number of 929,600 FFP3

¹ Document disclosed in Module 1

respirators held in the Welsh stockpile at the outset of the pandemic, only 59,600 (less than 7%) were in date.

15) This out-of-date stock was comprised of two groups of stock with expiry dates of 13 October 2016 and 1 August 2019, a position that was regularly reported to and known by the Welsh Government, as confirmed by Jonathan Irvine of NWSSP in his oral evidence to the Inquiry [Irvine; 14/111/1-24].

16) The cost of the FFP3 respirator stock held in the stockpile was £1,764,920 (as recorded within INQ000300270) and while not an insignificant sum, CBFJ Cymru submits that an in-date stockpile of this life-saving equipment ought to have been maintained, and that the failure of the Welsh Government to do so requires careful scrutiny.

17) Another area in which the Welsh stockpile was seriously deficient was long sleeved gowns, and of the target stock of 573,600, Wales had zero in stock - not a single surgical gown. Indeed, it is to be noted that when surveyed in February 2021, doctors in Wales identified the availability of FFP3 respirators and surgical gowns as key areas of concern [INQ000214235_0031].

18) Further, despite the focus in Exercise Cygnus on ensuring each organisation was aware of “how [the Welsh stockpile] would be distributed to them” [INQ000187149_0004], this plainly did not happen. Witnesses from Wales consistently acknowledged that there was a lack of communication and understanding of how, and to where, stock would be distributed during the pandemic.

Extent of the deficiencies: comparisons with the other UK nations

19) The Inquiry has heard evidence that the pandemic stockpiles were deficient in all four nations in the UK. However, this should not mask the extent of the failures in Wales. Again, the issue is most marked in respect of FFP3 masks.

20) By 12 March 2020, a DHSC email records that “Wales are in the most challenging position” of the 4 nations [INQ000551495_0002]. By that stage, Wales had already had to rely on 100,000 FFP3 masks from England, of which only 10,000 remained [INQ000551495_003]. Supplies were well below those available to the other UK nations per capita, as the table below demonstrates.

Table 1: FFP3 mask to population ratio

UK Nation	Number of in date FFP3 masks 12 March 2020	Population in mid-2020 (ONS)	Mask to population ratio
England	1,500,000	56,550,000	1:48
Scotland	113,000	5,466,000	1:38
Wales	10,000	3,170,000	1:317
Northern Ireland	99,000	1,896,000	1:19

Sources: INQ000551495 and ONS population statistics in mid-2020.

21) As shown above, Wales’ stockpile of FFP3 masks was woefully inadequate and well short of supplies in other UK nations. To put that in context, despite having almost double the population of Northern Ireland, Wales had only 10% of their supply of FFP3 masks.

Addressing the deficiencies: Just-In-Time contracts and re-testing of FFP3 masks

22) It remains unclear if, when and how the Welsh Government addressed deficiencies. An emergency ‘Just-In-Time’ order had been placed by 18 March 2020 [INQ000505360], but as the Inquiry has heard in oral evidence, ‘Just-In-Time’ contracts did not deliver. The Audit Wales report of April 2021 reported that the ‘Just-In-Time’ contracts failed. Audit Wales stated that, *“due to a lack of supply in the global market, these ‘just-in-time’ contracts did not deliver as fully as expected, with none of the FFP3 respirators being received”* [INQ000214235_0013 at §1.3].

23) The CBFJ Cymru invites the Inquiry to approach the evidence that the Welsh Government ensured swift re-testing of out-of-date FFP3 masks with caution. Mr Brace said that, as far as he was aware, there was no problem with out-of-date stock – it had been re-tested (it was simply that it had not been given a label to confirm it had been re-tested, thereby giving rise to concerns among the trade unions that stock was out of date). His evidence suggested, in other words, there was no problem with out-of-date stock at all [Brace; 6/182/19-6/183/5 and 6/183/20-6/183/24]. Similarly, Jonathan Irvine, director of procurement at NWSSP, gave evidence that the FFP3 masks were re-tested and in circulation by 25 March 2020 [Irvine; 14/114/18]. However, Welsh Government records show that as of 18 March 2020, the FFP3 stock remained out of

date, with re-testing achievable within 4 to 16 weeks to re-test, depending on the age of the stock [INQ000504943].

24) Regardless of the exact time frames of re-testing, the CBFJ Cymru is concerned about a number of aspects of the re-resting. First, it seems clear the body in Wales responsible for re-testing, Surgical Material Testing Laboratory (“SMTL”), did not have the expertise or relevant equipment needed to conduct re-testing. This is acknowledged in its own report (“Test Report, 27 February 2020”²) which records that aspects of the testing had to be subcontracted.³ Secondly, the face-fit testing SMTL undertook returned a high failure rate: it was a “fail” in half the cases, owing to face size, shape etc. - largely because they did not fit women (Test Report, 27 February 2020; Table 4 p.9; Discussion p.13 at §8.1). Given 70% of the health and social workforce are women, the figures are highly troubling. Plainly, if the masks do not fit, they offer no protection to the health care workers or patients they are designed to protect. Thirdly, the CBFJ Cymru notes the 3M Respirator timeline analysis report makes reference to the SMTL report and claims it “*demonstrates that the products are safe to use*” (INQ000269725 entry for 28 February 2020). The CBFJ Cymru questions how this can be the case given, as the report itself acknowledged, such a high proportion failed the fit test.

Reasons for deficiencies in Wales’ stockpile

25) It must be stressed that the deficiencies cannot be attributed to a UK-wide PIPP strategy which underestimated the demand in the event of a pandemic: the Wales stockpile did not contain that which it was supposed to contain. And it was the responsibility of the Welsh Government, not Westminster, nor the NWSSP, to maintain adequate and in-date stock.

26) As to why stocks were out-of-date, Mr Irvine could not assist when he gave evidence at the Inquiry. He made clear that the Welsh Government were aware of the problems: there were regular stock reviews carried out with Welsh Government officials. “*I’m not trying to be evasive*”, he said, “*that would have been a decision that Welsh Government would have had to have taken and it would have been a matter for them to have*

² This document is Appendix B referenced in INQ000269725_0001 entry 28.02.2020 re. Welsh colleagues

³ The CBFJ Cymru observes that even today, SMTL’s current UKAS certificate demonstrates it does not have the accreditation to test FFP3 masks; if it were the case it was also not accredited in 2020, the group questions why it was instructed to conduct the re-testing on behalf of NWSSP in the first place and notes the obvious risk to healthcare workers (and patients) arising from such a decision.

answered” [Irvine; 14/111/7-11]. The CBFJ Cymru observes that the Welsh Government have not answered that question. Notwithstanding witness statements totalling hundreds of pages, and notwithstanding thousands of exhibits, the answer to this very simple question remains elusive.

Conclusion

27) The CBFJ Cymru urges the Inquiry to view with caution the assertions which appear (verbatim) in several statements prepared by those working for the Welsh Government that the stockpile was “*crucial during the first four months of the Covid-19 response and gained time to enable the NHS Wales Shared Services Partnership to successfully secure ongoing PPE supplies*” [Slade; INQ000506956_0042 at §174; Gething INQ000536418_0024 at §104]. Talk of “success” is inappropriate. Supplies were not secured. Members of the group experienced firsthand the devastating effects of shortages of PPE and inadequate PPE. The Chair will have to make recommendations following this Inquiry. And yet, in the absence of any recognition and explanation of the failure of the Welsh Government to maintain adequate stockpiles, the opportunity for the Welsh Government to learn lessons for the future is necessarily limited.

PPE AND EQUIPMENT IN HOSPITALS

Introduction

28) After some introductory remarks, this section on PPE and equipment in hospitals covers:

- a) Wales “never ran out of PPE”: a misleading claim
- b) Extent of shortages of PPE and equipment in hospitals
- c) Reasons for shortages/inadequacies in type of PPE in hospitals
 - i) Distribution problems
- d) Conclusion

29) The Inquiry will consider principal issues in the distribution of PPE [**LoI 4 §16**].

30) The Inquiry will be aware that many CBFJ Cymru members suffered bereavement following a hospital or care home acquired infection. The CBFJ Cymru believe that the lack of adequate PPE within Welsh hospitals and care homes was a major cause of the high levels of infection and deaths experienced. Such nosocomial transmission is

one of the principal symptoms of the failure to distribute PPE and equipment to hospitals.

Wales “never ran out of PPE”: a misleading claim

31) The Inquiry has been told repeatedly by the Welsh Government and its politicians that, on a national level, PPE stocks in Wales never ran out [e.g. witness statement of Mark Drakeford INQ000528293_0007]. Alan Brace, Andrew Slade and Jonathan Irvine all repeated that Wales “never ran out” of PPE when they gave evidence to the Inquiry.

32) The claim that Wales “never ran out” of PPE has the potential to be a highly misleading claim. This is because those monitoring and distributing the stock – NWSSP - were also the ones managing requests for PPE, determining what proportion of any request would be supplied. Mr Irvine may not have liked the term “demand management” when asked in evidence whether Wales engaged in “demand management”, but that is the very process he described:

“I wouldn’t term it in that way [demand management]. Certainly in the initial two, three weeks, maybe four weeks...most of March...We were dealing with a finite amount of stock that was held in the PIPP stockpile, with no, certainly up to the third week of March, I would argue, no clear line of sight as to how that was going to be replenished or if it was going to be replenished. Bearing that in mind and hearing in mind what’d I’d just previously said about potential...almost panic to get product into the hospitals, we had to make sure that all PPE stockpile was available to all health boards and trusts across Wales. We couldn’t have a position where one health board came in and took 60-70% of the stock leaving others without anything. So in this respect we had to make sure there were sufficient quantities for everybody. So we had to make a determination” [Irvine; 14/130/20-14/131/17].

33) To put it another way: if Wales did not run out, it is not because demand was met, it was precisely because demand was not met, NWSSP allocating in order to ensure its stockpiles did not run out, rather than allocating to meet need.

34) In any event, even if Wales did not run out at a national level, the more relevant issue is why healthcare workers and patients in hospitals did not have the necessary PPE.

Extent of shortages of PPE and equipment in hospitals

35) Just over five years ago, Wales reported one of its first deaths from a hospital acquired covid infection. Douglas Miles was admitted to the Holywell Community Hospital in Denbigh for an operation. But he caught covid whilst in hospital and, tragically, on 29 March 2020, passed away. His daughter, Sylvia Parry, said “there was no PPE at the time and my father was just a sitting duck in the hospital”. She observed undertakers attending in full hazmat suits, whilst healthcare workers, reliant on supplies from Local Health Boards, had nothing. It would prove to be one of the first of many deaths in Wales from nosocomial covid infection. And it is a story to which many in the group relate:

- a) Ann-Marie Richards (from whom the Inquiry heard in the Module 5 impact video). Her husband went into hospital in December 2020 to be treated for sepsis. He caught covid in his ward and tragically never recovered. When Hywel Dda Health Board reviewed his case, they found that on Mr Richard’s ward, 25 patients had tested positive for covid, and 25 staff members had tested positive for covid. The Board simply told Mrs Richards, opaquely, that “exposure to multiple hospital environments would have made Mr Richards more vulnerable to hospital acquired infections”.
- b) Sam Smith-Higgins, co-leader of the CBFJ Cymru group. She told the Inquiry in her oral evidence in Module 4 [2/115/21-117/22] about her fears for her 73-year-old father, who was admitted to hospital in early January 2021 for cancer related treatment and was immune suppressed and vulnerable. He was not permitted access to a high efficiency particulate arresting (“HEPA”) filter (even though they are low cost and portable, and even though Ms Smith-Higgins offered to source one herself). Nor was he ever offered a mask. Tragically, just three weeks after being admitted to hospital, he died from a Covid-19 infection acquired in hospital.
- c) Anna-Louise Marsh-Rees, co-leader of the CBFJ Cymru group. Her father went into hospital for a gall-bladder operation. On his non-covid ward, 21 patients had covid. Tragically, of those, 12 - including Anna-Louise’s father - passed away from Covid-19.

36) There are many more such examples. The experience of many in Wave 1 was that they would attend hospital to find healthcare workers “with zero to minimal PPE”. In Wave 2, members saw healthcare workers generally equipped with surgical masks, gloves and aprons, but no FFP3. By that stage, of course, the nature of aerosol

transmission of Covid-19 was known, and yet healthcare workers were under-protected. The result was that patients caught covid whilst in hospital.

37) It was well known in communities across Wales, particularly as the pandemic went on, that there was a high risk of nosocomial transmission upon admission to hospital. Families felt a grim inevitability that, if admitted to hospital during the pandemic, their loved one would contract covid. Their fears were well founded: data from Public Health Wales ("PHW") showed that, as of 24 February 2021, of the 1,002 patients in Welsh hospitals testing positive for covid, 529 of these (53%) were classified as "hospital onset" cases [INQ000227307_0002]. The situation has not improved: PHW data as of 09 February 2025 shows some 83% of inpatient Covid-19 cases in Wales were the result of hospital-acquired infection.

38) Examples from healthcare workers are consistent with the accounts from members of the group. We note by way of illustrative example only:

- a) a consultant in Wales told the British Medical Association: "At the start, despite knowing of the virus spread, no PPE was provided. Not even masks let alone thinking of level 2 PPE for aerosol generating procedures. This was when many of my colleagues and I became ill."
- b) a GP in Bangor spoke of "rationing" out their PPE, having to use it only on patients who were strongly suspected of having Covid-19 through symptoms such as a cough or fever. Staff were also having to wear goggles procured from a DIY shop.
- c) Gareth Davies, a nurse working in Llandough Hospital, warned his family he was having to work in a paper mask, without PPE. He contracted coronavirus and passed away in April 2020.

39) Examples of re-use of PPE tell a similar story of shortage. As Adam Morgan from Wales TUC observed in his witness statement in Module 2B [1NQ000400723_0024]:

86. The Welsh Government did not follow the UK guidance to reuse PPE. Nevertheless a GMB representative reported that staff in Welsh hospitals were being encouraged to share PPE that should have been single use, including versa-flow hoods that workers would breathe through for entire shifts. When staff complained, they were told that they had no choice. Staff were alarmed by the risk of infection created by reusing colleagues' hoods, and the suggestion was only dropped after significant resistance from Unite. I was told

by CSP members that the advice regarding appropriate PPE appeared to be based on availability rather than the level of protection afforded [Exhibit AM/58 - INO000339547].

40) The suggestion by PHW, in November 2020, that “deeply ingrained and cultural” staff behaviours was responsible for the high rate of transmission in hospitals was, to say the least, surprising [INQ000396261_0001] (one Health Board reported the infection rate was 24% among staff, as compared to 1% in the community). No doubt, the many patients and healthcare workers who experienced the shortages might suggest a more obvious reason for the spread of infection: a lack of PPE.

Poor ventilation in Welsh hospitals

41) PPE shortages were exacerbated by inadequate ventilation in Welsh hospitals. The CBFJ Cymru reminds the Inquiry of the evidence of Dr Shin in Module 3 that there was insufficient consideration given to ventilation beyond the opening of windows. Dr Shin in his oral evidence recommended common-sense alternatives to installing new ventilation, namely UV filtration system and HEPA filters [Shin; 08/172/3–08/174/4] which were low cost and portable. Baroness Morgan flippantly joked that a HEPA filter had been her most disappointing Christmas present [Morgan; 35/195/6-8]. On the contrary, for CBFJ Cymru, HEPA filters are a valuable piece of equipment which could have reduced nosocomial transmission rates and potentially saved lives. The Inquiry will also be aware of the evidence in Module 2B of the Chief Nursing Officer for Wales, Professor Jean White, who explained that the hospital estate in Wales was old, and would not have therefore been well ventilated [White; 6/114/20-25].

Reasons for shortages/inadequacies in type of PPE in hospitals

42) Whether as a result of “demand management” by NWSSP or not, even if Wales did not run out of PPE, that is of little comfort to those who experienced shortages at a local level. What good is a long-sleeved gown and FFP3 mask in a warehouse in Denbigh, when it is needed at the local hospital, where covid is spreading through the ward, among staff and patients alike? Or, as Professor Manners-Bell put it:

“not getting [goods or] PPE to the right place means a critical supply chain failure. You [might as well not] have bothered to have had those goods in the

first place if you're not able to get them to where they're needed at the right time, to the right people." [Manners-Bell; 5/12/22].

43) Failure of planning and preparation resulted in a Welsh stockpile that was woefully lacking in Respiratory Protective Equipment such as FFP3, and faced with no means of procuring sufficient stock, this equipment was rationed to ICU settings and AGP procedures by means of the IPC guidance, leaving patients and staff outside of these settings more vulnerable to infection. The group considers this to be one of the main underlying reasons for the shortages – and is explained in further detail above (Pandemic Stockpile) and also below (IPC Guidance and FFP3 masks).

44) A further reason for shortages is distribution of PPE.

Distribution problems

45) Mr Slade (Welsh Government) suggested problems in supply and distribution related to a lack of information about (i) what was needed and where and (ii) what stocks were held at a local level. There was, apparently, no system of knowing how much stock hospitals had – they were starting from scratch. So, problems arose because there were inadequate flows of information and intelligence.

46) Mr Brace (Welsh Government) suggested confusion in distribution was caused by IPC guidance: *"the change in guidance...caused a lot of tension at the direct service end around what PPE was required and did we have the right mix of PPE"* [Brace; 6/202/19-24]. He suggested that guidance led to tensions in staff understanding what was required and therefore supplied: his claim was unsubstantiated, but in any event was a red herring, given (as the Inquiry has heard in previous modules) changes in IPC guidance did not substantially alter PPE e.g. mask wearing.

47) And like Mr Slade, Mr Brace suggested there was plenty of stock, but there were problems with information about that stock. He said: *"there weren't any hospitals without stock...but there clearly was coordination issues at the hospital end about what stock was held and where, and how to distribute it as quickly as possible across the various sites and hospitals and hospitals within the hospital"*. [Brace; 6/189/1]. He described it as a *"disconnect"* between the Local Health Board's understanding of available stock, and NWSSP's understanding that they had *"pushed out enough stock to the NHS"* [Brace; 6/189/8-6/190/4]. He later seemed to suggest it was simply about

speed: it went to a distribution point [Brace; 6/204/5-14], but it was about how quickly it could get to the wards: *“every hospital has got a central receipt and distribution point that then distributes to wards. So there would have been stock in receipt and distribution points and I guess the challenge was how was that – how quickly...”* [Brace; 6/204/9-13].

48) And finally, Mr Brace suggested problems in distribution were because NWSSP operated a “push” system, rather than a demand system – which was how they normally operated with the local Health Boards [Brace; 6/205/4-8]. He did not elaborate further.

49) Such explanations raise more questions than answers. NWSSP had been supplying PPE to Health Boards and hospitals for the best part of a decade when the pandemic started (since 2011). Distribution paths and delivery points must have been well established. Why had not even the most basic stock management system been put in place? Why did NWSSP use a “push” system, when it had not done so previously? And if it is correct that there was plenty of stock floating around the NHS estate in Wales, why did the problem go unattended or unsolved, once it was realised (certainly by 30 April 2020, when the military logistics report was produced [INQ000470703] that this was a serious problem.

50) Whilst the Welsh Government felt, as Mr Brace said in evidence, “confident and assured” they had a grip on the situation in April/May 2020, this was evidently not the case. Healthcare workers and members of the group alike witnessed shortages throughout 2020 and into 2021:

- a) In April 2020, an RCN survey of nurses in Wales reported on the sufficiency of particular PPE items: only 52% had sufficient eye protection; 46% - Type IIR masks, 63% - FFP3 respirators, 57% long sleeved gowns.
- b) In February 2021, a BMA survey of doctors in Wales reported that just 37% had sufficient PPE for non-aerosol generating procedures, whilst 44% said that it was not adequate. As to PPE items that would help doctors feel safe, 88% identified FFP3 masks and 45% identified long-sleeved disposable gowns [INQ000214235 - Procuring and Supplying PPE for the covid-19 pandemic, Audit Wales 2021].

51) The reasons that essential PPE and equipment failed to reach the frontline are far from clear. The Inquiry heard from Welsh Government witnesses and NWSSP. They, by

inference, pointed the finger to failings at a more local level. That may be correct, incorrect or partially correct. The position is not known. Significantly, no evidence was called from those operating at a more local level, such as the Local Health Boards, who may have been able to provide the Inquiry with valuable insights into whether and why there were distribution and logistics problem at a Local Health Board or hospital level.

Conclusion

52) Notwithstanding the repeated claims that the PPE stocks distributed by the NWSSP never ran out, the reality was that they did; or at least stock did not reach those who needed it. Plainly healthcare workers are among those who needed it most.

53) Many of the group question why the Welsh Government was so slow to react to the issue. Many of them question why the staff and patients and residents in hospitals and care homes were unable to take the precautions necessary to curb the spread of the virus. They believe that the reason why Wales has the highest rate of nosocomial deaths must have been due to the lack of any PPE, or appropriate PPE, resulting in mass cluster outbreaks in wards and care homes across Wales.

54) Given that there was such limited exploration as to why those that needed PPE did not have it, the concern of the CBFJ Cymru is that there remains a significant gap in understanding this key aspect of the module. And, again, without an understanding of the problem, there can be no confidence or assurance that the Welsh Government have learned any lessons for the future.

PPE AND EQUIPMENT IN CARE HOMES

Introduction

55) After some introductory remarks, this section on PPE and equipment in care homes covers:

- a) Wales “never ran out of PPE” in the social care sector: a misleading claim

- b) Extent of shortages of PPE and equipment in care homes
- c) Reasons for shortages/inadequacies in type of PPE in care homes
 - i) Delays in recognising the PPE needs of care homes
 - ii) Distribution problems
- d) Other concerns about PPE and equipment in care homes
 - i) Shortcomings in the level of protection offered in care homes
 - ii) IPC guidance for care home workers on the use of PPE was inadequate

56) The Inquiry will be considering the extent to which systems for distribution and procurement of PPE met the needs of the care sector [Lol 4 §18].

57) The supply of PPE to care homes is a particular concern for the members of the CBFJ Cymru, a large number of whom lost loved ones in care homes during the pandemic.

Wales “never ran out of PPE” in the social care sector: a misleading claim

58) Here, again, the narrative from the Welsh Government is that, like the healthcare system, the social care system never ran out of stock. For example, Mr Brace said that the only time he was aware of a care home running out of PPE was a false alarm:

“a call came through to the ministerial team that one of the care homes in one of the local authorities in Wales had run out of PPE, and there was none available. I contacted Mark Roscow in Shared Services who said that’s very unusual because the joint equipment store has been replenished. He sent a van there and actually the joint equipment store was complete with stock, but there were clearly communication or distribution issues just between that care home, the local authority, and the joint equipment store” [6/201/9-21].

59) The basis upon which this is said has not been explained or explored. To the extent that it relies on stock data from the Welsh Government/NWSSP that Wales never ran out of stock at a national level, such a claim is potentially misleading: demand management ensured that it never ran out, irrespective of demand and/or need (see above in respect of hospitals).

In any event, the claim is misleading. There is an overwhelming amount of evidence that shows that those in care homes did not have the PPE, and type of PPE, they

needed. And those who experienced first-hand the shortages, and the use of inappropriate PPE, will no doubt find it hard to understand why the PPE Supply and Distribution Cell for the Welsh Government, headed by Mr Brace, was apparently so misinformed. The failures to supply care homes with adequate and appropriate PPE and equipment are widely reported; they cannot be denied.

Extent of shortages of PPE and equipment in care homes

60) Helena Herklots, the Older People's Commissioner for Wales, wrote to the Welsh Government on 14 April 2020, expressing concern about access to PPE in care homes. She explained the context for her letter when she gave evidence to the Inquiry on 28 February 2024 in Module 2B:

"So at that point I was having some dialogue with care home owners, I was hearing from care home staff and also family and friends of people living in care homes. What I was hearing in relation to PPE is that the supply was inconsistent. So some homes had the PPE that they needed, but others were really struggling to get it, trying to purchase it directly themselves, or struggling to secure it from the distribution mechanisms that were then in place... So it was causing quite a lot of homes a lot of anxiety and stress about not having the PPE that they needed. And I think also they were concerned about, if they did have it, whether that supply would continue consistently for the time that they needed it." [Herklots; 2/124/5]

61) Dr Chris Llewelyn, Chief Executive Officer of the Welsh Local Government Association (WLGA), reported similar issues among local authorities (the care sector):

"While it was reported that Shared Services' did not run out of stock for any item of PPE during the pandemic (Exhibit CL/101 - INQ000473214: 210315 AW PPE Report Working Draft), which may have been true for NHS bodies, there are accounts of local authorities being unable to obtain supply of requested items through Shared Services at points throughout the pandemic" [INQ000518355_0020 at §46].

62) And furthermore, Dr Chris Llewelyn observed that even if NWSSP made available the quantity of stock (such that "demand appeared to be met") this was not necessarily the correct stock:

“47. The WLGA is also aware of circumstances where demand for PPE was met 'on paper' however in practice the supplies could not be utilised by care professionals. For example, throughout August and September 2020 the overall quantity of nitrile examination gloves available to the care sector was sufficient, but they were not available in sizes that could be used by care professionals...

48. This issue was not exclusive to gloves and issues were experienced with other PPE equipment. For example, aprons issued as 'one size fits all' did not provide significant coverage to some care workers and there were concerns that there was a risk of workwear being contaminated during personal care interventions. With regards to masks, some workers experienced a reaction to certain brand masks which potentially contained latex, while other brand masks did not mould around the nose appropriately resulting in staff constantly touching them to re-adjust. These products were eventually withdrawn from use, but at a point in time would have been considered as meeting PPE demand”. [INQ000518355_0020-21 at §§47-48]

63) Statements from Ms Herklots and Dr Llewelyn are consistent with the experiences of the members of the group itself. Catherine Griffiths' tragic experience epitomises this. Her father contracted covid in his care home in Aberystwyth. She describes the last time she saw him:

“On 16th November 2020, I was invited to the home to say 'goodbye' to Dad. I wanted to go in and be by his side and to hold and comfort Dad; my brother urged me not to. The level of PPE in the home was abysmal; we could see the nurse wearing just an apron and a flimsy surgical mask. I was forced to say goodbye to my father whilst standing in the icy rain, outside his window.”
[INQ000474759_0020 at §69⁴]

Reasons for shortages/inadequacies in the type of PPE in care homes

64) The claim that Wales never ran out of PPE in the social care sector (evidently incorrect) is in any event an irrelevant one. To repeat the evidence of Professor Manners Bell: *not getting [goods or] PPE to the right place means a critical supply chain failure. You*

⁴ Statement disclosed in Module 6

[might as well not] have bothered to have had those goods in the first place if you're not able to get them to where they're needed at the right time, to the right people." [Manners-Bell; 5/12/22]. What good is a mask in a warehouse in Bridgend, when it is needed at the local care home, where covid is spreading through the home, among staff and patients alike? The more relevant question is why care homes experienced such shortages and what were the nature of the shortages. The CBFJ Cymru note the following reasons for shortages from the evidence available:

- a) Delays in recognising the PPE needs of care homes
- b) There were distribution problems

Delays in recognising the PPE needs of care homes

- 65) There was a delay in providing PPE to care homes. As Mr Slade told the Inquiry, the likely need to deliver PPE to social care settings was recognised as early as 18 February 2020 [INQ000470674]. Yet it was not until 19 March 2020 that the remit of the NWSSP was extended to procure and supply care homes. Those operating at a local authority level felt that the Welsh Government failed to recognise the needs of social care settings, as it prioritised supply of PPE for the NHS [INQ000518355_0009 at §19 and §21].
- 66) During the first few months of Covid, and notwithstanding the expanded role of the NWSSP on 19 March 2020, councils were seeking supplies of PPE from the NHS, but such supplies were dependent on a positive case being identified, and in any event the nature and timing of provision from NHS stock was unknown. Local authorities had to forecast demand, place their own orders and chase supply [INQ000518355_0010 at §§20-22]. By May 2020 only two thirds had their PPE needs met by NWSSP. It was not until much later – September 2020 – that a Service Level Agreement between the NWSSP and the WLGA was reached [INQ000518355_0010 at §§29-30; 43], an agreement only formalised in a letter to social care providers on 12 October 2020. By that stage, of course, Wave 2 of the pandemic was already underway.
- 67) Mr Slade did not accept care homes had been overlooked whilst the NHS was prioritised. Nor did he accept that the Welsh Government could and should have acted more quickly to assist care homes. But the recognition by both himself and Mr Brace that, in a future pandemic, NWSSP should or would provide PPE immediately for the care sector tells you that the response to supply PPE to care homes was too slow.

68) The delay is epitomised by the reaction of the Welsh Government to the request from Ms Herklots for an Action Plan to address the problem of care homes in Wales. Ms Herklots met Julie Morgan, Deputy Minister for Health and Social Services, on 9 April 2020, to raise concerns about the situation for staff and residents in care homes, and the anxieties felt by their loved ones. By that stage, as Ms Herklots noted, Ms Morgan had announced that there had been confirmed or suspected cases in nearly a third of Wales' care homes. Further to the meeting, on 14 April 2020, Ms Herklots wrote to the Ms Morgan and invited her to make an Action Plan [INQ000184935]. She explained the rationale for the Plan when giving evidence to the Inquiry in Module 2B:

"I struggling to see how the work to help older people living in care homes and those working in them, how that was being led and co-ordinated... and if I was struggling to see it, it was going to be even more difficult for people in care homes and families and friends to actually see what was happening....there needed to be an urgency and focus, that I couldn't see at the time." [Herklots; 2/130/3].

69) Ms Herklots asked Ms Morgan to lead and set out an action plan to drive faster progress, faster action to protect older people. By reply on 21 April 2020 [INQ000184940] Ms Morgan said she was:

"...not convinced that an additional plan of action over and above those arrangements...will add value here but we will certainly report on progress via the Social care Sub-group."

70) Ms Herklots was, unsurprisingly, angered that Ms Morgan was suggesting that working on an action plan *"would add no value, at a time when people were dying in care homes, where families were distraught."* [Herklots; 2/131/2]. It took a report published on 21 June 2020, *"Care Home Voices: A snapshot of life in care homes in Wales during Covid-19"* [INQ000181725] to jolt the Welsh Government into action. An Action Plan was eventually published on 30 July 2020, over three and a half months after the Welsh Government had been asked to prepare a plan. The CBFJ Cymru is concerned that valuable time was lost to protect this most vulnerable of populations in Wales.

Distribution problems

- 71) Another reason for lack of PPE and appropriate PPE in care homes appears to have arisen from distribution problems. We know that NWSSP supplied stock from its national stores to Local Authority Joint Equipment Stores, for onward distribution to the care sector by local authorities. We also know that this process did not work as it should have.
- 72) Mr Irvine said there was “more than enough PPE in the joint equipment stores...but the Joint Equipment Stores or local authorities more generally weren’t necessarily aware of what was actually there” [Irvine; 14/154/16].
- 73) Mr Irvine’s suggestion is hard to understand: it implies local authorities and care homes, desperately in need of PPE, could have had more than they needed, if only they’d checked their local joint equipment store. If that is right, then the obvious question arises: why was the matter not be resolved easily, by simple and better communication between NWSSP, local authorities, and the end user?
- 74) Mr Irvine’s suggestion is also hard to understand given Stock Watch, the inventory management system designed to enable NWSSP to understand what was needed and where, was unfit for purpose (and was recognised by Mr Irvine as such). The system relied on email updates from local authorities, or, from November 2020, direct input from local authorities themselves. Whichever the method, NWSSP were not able to “understand that we were fulfilling their full requirements” [Irvine; 14/153/22] and there were “gaps in how much stock [those] areas actually required” [Irvine; 14/135/25]. If the Inquiry were to accept that the joint equipment stores were full to overflowing, that would have been by luck, rather than by design. It is a question of “if”: the Inquiry has not heard from the local authorities and care homes providers; it might be that they would provide some useful information on how or why the system failed from their perspective. They may even have a narrative to counter the implicit suggestion that failures lay with them, at a local level.
- 75) The Welsh Government had little to offer by way of their own insights into problems in care homes. Mr Brace said he “*would not want to comment about every instance of where that was felt in social care*” [Brace; 6/203/18]. Indeed, he did not comment on any instance – beyond saying there was one false alarm. Nor could Mr Irvine help – he said “*the more important issue*” was to understand the responsibilities of NWSSP and “*where they started and where they ended*” [Irvine; 14/155/17-20] – i.e. it was not the responsibility of NWSSP. Such siloed thinking perhaps reveals more than Mr Irvine

intended. It certainly assists the CBFJ Cymru in understanding why problems, once identified, would not be resolved. Unlike Mr Irvine, for the members of CBFJ Cymru, the most important thing was not where NWSSP's role started and ended. It was why healthcare workers and residents in care homes were so overlooked and poorly serviced when it came to PPE and essential healthcare equipment, and why their loved ones died because a lack of proper protection.

76) Finally, there is a shortcoming underpinning these distribution concerns, which suggests distribution to care homes in Wales was always going to be problematic. As the former First Minister, Mr Drakeford, admitted in oral evidence during Module 2B [Drakeford; 11/211/15], there was no single register of the location of every care home in Wales. Having regard to this position, the CBFJ Cymru suggests that it will be important for the Inquiry to understand how the Welsh Government was able to ensure the supply of necessary PPE to care homes, when the extent of their existence and operation was not known.

Other concerns about PPE and equipment in care homes

77) The CBFJ Cymru note the following additional concerns in relation to PPE and equipment in care homes in Wales:

- a) Shortcomings in the level of protection offered in care homes
- b) IPC guidance for care home workers on the use of PPE was inadequate

Shortcomings in the level of protection offered in care homes

78) There were shortcomings in the level of PPE protection in care homes. The NWSSP packs prepared and distributed to local authorities for onward distribution to care homes contained a fluid resistant surgical mask, apron, gloves and eye protection [INQ000470675]. These were the items that were subject to the SLA formalised in September 2020 and about which care homes were formally notified on 12 October 2020. These items continued to comprise the stock made available to care homes via their local authorities throughout the pandemic (as shown by data from Stock Watch, the electronic stock management system) [INQ000436116]. Yet, as set out below, FFP3 masks - absent in the packs - were essential in preventing the spread of aerosol transmission.

IPC guidance for care home workers on the use of PPE was inadequate

79) The IPC guidance for care home workers on the use of PPE was inadequate. PPE guidance for care homes was based on UK/national level guidance. It therefore suffered from the same failings as nationally agreed IPC guidance (further details in the section below).

80) The effect of the failure to recognise the asymptomatic nature of the virus, and its airborne transmission, was particularly marked in care homes. The Minister for Health and Social Care, Vaughan Gething, announced on 16 March 2020 that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. A letter to social care providers on 18 March 2020 following Mr Gething's announcement confirmed (i) PPE was for those directly caring for confirmed or suspected cases, and (ii) that higher level of PPE was "unlikely to be needed" in a social care setting – such equipment only being needed by those undertaking AGPs [INQ000470681].

81) Further, PPE guidance for social care settings was said to be adapted by Public Health Wales to a social care setting [INQ000506956_0068 at §287]. However, in the opinion of those working in the sector (who were already disadvantaged by the lower levels of training in PPE use as compared to NHS staff) the guidance was poorly adapted. Dr Chris Llewelyn, Chief Executive of the WLGA, summarised the problem as follows:

"Guidance, where available, was predicated on NHS applications and did not easily translate into non-hospital care settings...it was also not clear about the specific application of PPE required in different situations" [INQ000518355_009 §19; §34].

82) The lack of clarity had a knock-on effect on supply: the guidance left room for interpretation and as such affected usage, and in turn hampered the ability to accurately predict demand for PPE in the care sector [Dr Chris Llewelyn, INQ000518355_017 §36].

83) For completion, we note that the most recent PHW IPC guidance for Acute Respiratory Infections ("ARIs") in Wales (2024-2025)⁵ recommends that social care staff use *"FRSM (type IIR) when working in respiratory care pathways and when clinically caring*

⁵ Infection Prevention and Control Measures for Acute Respiratory Infections (ARI) for Health and social Care Settings – WALES 2024 Version 3.0a.

for suspected/confirmed COVID-19 and Flu patients” (p.8/17) and only recommends FFP3 masks “if an unacceptable risk of transmission remains following the hierarchy of controls” (p.15/17). It is not known how those in care homes – a “high risk setting” because they cannot mitigate risk with a hierarchy of controls (p.6/17) - are expected to conclude there is “unacceptable risk following the hierarchy of control”, such that FFP3s are required. It seems therefore that current guidance for care homes does little to correct deficiencies in earlier guidance.

VENTILATORS, OXYGEN AND CPAPS

84) The concerns of CBFJ Cymru in this module have not been confined to PPE but extend to key equipment such as ventilators and CPAPs.

85) The Inquiry heard much evidence as to the procurement activities for ventilators by the UK government. Of course, it is recognised that procurement of these significant pieces of equipment took place on a UK-wide basis. Whilst it is clear therefore that Wales benefited from such UK-wide procurement, a more detailed picture of whether Wales had sufficient ventilators (and how that was measured) is less clear. Certainly, its members experienced shortcoming and failures in access to ventilators and other key equipment, as the examples below show:

- a) Marita Edwards was admitted to hospital in February 2020 for a routine operation. She was otherwise fit and healthy. But she caught covid whilst in hospital and tragically she passed away. Her son, Stuart Loud, questions why she was not put on a ventilator, and whether this decision was a result of a lack of resources, which meant staff had to hedge their bets on whether younger people might be infected and would need that equipment.
- b) Paul Jones (who has provided a witness statement to the Inquiry) and his wife Karen lost their 25-year-old daughter, Lauren, in December 2020. Staff delayed getting her onto a ventilator until her oxygen saturation level was at just 10%, almost 24 hours after being notified that she would need to go on a ventilator. He wonders why a ventilator was not made available sooner.

86) The only witness to be called to give evidence on key equipment such as ventilators and CPAPs in Wales was Richard Davis, the lead government official with the Critical Equipment Requirement Engineering Team (CERET). He gave evidence to the Inquiry for some 30 minutes. He could not assist with issues of access to ventilators and CPAPs, save to say that CERET was directed away from involvement in

making/procuring ventilators and CPAPs – they were simply told what to do by NWSSP. He did say, adopting a now familiar line, that Wales “*never ran out of vital, critical equipment*” [Davis; 14/169/22]. The CBFJ Cymru invites the Inquiry to treat such claims with caution. There has been no scrutiny of such claims, and they sit at odds with the experience of the group’s members.

INFECTION PREVENTION AND CONTROL (“IPC”) GUIDANCE ON FFP3 MASKS

Introduction

87) After some introductory remarks, this section on IPC Guidance and FFP3 masks, this section sets out:

- a) Evidence that there is serious doubt that the IPC guidance was correct
- b) Evidence that that IPC guidance was driven by resource/constraints in supply
- c) Conclusion

88) The Inquiry will consider the operation and effectiveness of guidance in relation to key medical equipment and supplies [**“Outline of Scope” §3; Lol §§4-10: “Structures, systems and processes”**]. Although the primary focus of the Inquiry here may be guidance in respect of procurement, the CBFJ Cymru nevertheless is concerned to highlight the significant role played by IPC guidance in respect of PPE procurement.

89) The IPC guidance was a product of the UK IPC Cell, which brought together IPC leads from NHS and public health bodies across the four nations, including Wales. It set out what level of PPE protection was needed, and by whom, in different clinical scenarios. Thus, IPC guidance was critical in shaping the decision making for the procurement and supply of PPE [w/s Dr Eleri Davis, Public Health Wales, INQ000557344 at §42].

90) The nature of the IPC guidance in so far as relevant to PPE procurement is summarised in the witness statement of Jonathan Marron [INQ000528391_0063 to _0068]. In short, the IPC guidance was that from 13 March 2020, FFP3 masks were recommended only for treatment in ICU, or for Aerosol Generating Procedures (“AGPs”). This guidance was said to be “*based on the reasonable assumption that the transmission characteristics of Covid-19 were similar to those of the 2003 SARS-CoV outbreak, mainly transmitted through respiratory droplets generating by coughing and sneezing, and through contact with contaminated surfaces*” [w/s of Jonathan Marron INQ000528391_0066 §245; IPC guidance at INQ000325350]. This “reasonable

assumption” requires scrutiny, given the large body of evidence pointing to transmission via aerosol (in addition to droplets).

91) Against this background, CBFJ Cymru makes two main submissions:

- a) There is serious doubt that the IPC guidance was correct
- b) There are serious concerns that IPC guidance was driven by resource/constraints in supply

Evidence that there is serious doubt that the IPC guidance was correct

92) First, there must be serious doubt as to whether the IPC guidance was correct to limit the use of FFP3s to ICU/AGP scenarios. This is not a question of having the benefit of hindsight. This is a question of failing to fully acknowledge the risk at the time the IPC guidance was issued that Covid was spread via aerosol transmission.

93) The CBFJ Cymru has considered the closing submissions of the British Medical Association (Module 1 §§20-25; Module 2 §§37-61 and Module 3 §§37-48) and invites the Inquiry to consider them afresh reporting on Module 5, given the cross-cutting nature of the PPE issue. Suffice here to say that Professor Van Tam’s understanding, as at January 2020, was that *“the historical HSE statutory position is that maximum level RPE is required”* [INQ000151353]. Such a position was consistent with advice received in late March/early April from a coronavirus expert in Belgium to medical officers in the UK: *“It must also be understood that aerosol transmission means workers need FFP2 for effective protection. The surgical masks are not protective enough, but they do have a place”* [INQ000454404]. By that stage, experts such as Professor Catherine Noakes in the UK were already concerned that airborne transmission was being *“overlooked by the public health bodies who were focussed almost exclusively on exposure to domestic droplets when people were at close proximity and on the role of contaminated hands and surfaces”* [INQ000236261_0049].

94) In this Module, the Inquiry heard from Rosemary Gallagher, Professional IPC Lead at the RCN. She confirmed that, in her view, aerosol transmission was overlooked, with the result that healthcare workers were placed at unacceptable risk in the workplace [Gallagher; 10/57/1]. IPC guidance prevailed which meant that healthcare workers were not given the Respiratory Protective Equipment necessary to prevent infection due to airborne transmission. The RCN advocated and campaigned for this at the time – this was not a question of hindsight.

95) Dr Eleri Davies prepared the corporate witness statement on behalf of PHW for the Inquiry for Module 5 [INQ000557344]. At §93, she states:

“Public Health Wales did not advise the Welsh Government that COVID-19 was only communicable following AGPs. We were aware that modes of transmission included droplet/aerosol and contact. Our communications with the Welsh Government were regarding the UK COVID-19 IPC Cell guidance and ensuring that the Welsh Government were familiar with any updates to that guidance.” [INQ000557344_0024]

96) However, during the pandemic, it seems PHW did in fact advise it was only communicable following AGPs, and did advise the Welsh Government that the virus was not transmitted by aerosol transmission. In an email dated 24 March 2020 to the Deputy Chief Medical Officer, Professor Chris Jones, Dr Davis reported:

• Based on the current available evidence, the COVID-19 virus is transmitted between people through close contact and droplets, not by airborne transmission. The PPE required for contact and droplet precautions in the UK is Gloves, Aprons, Fluid Repellent Surgical Mask (FRSM) and eye protection (risk assessed depending on risk of splash) — FFP3 masks are only required for aerosol generating procedures (AGPs).” [INQ000252515_0003].

97) This continued to be the case up until December 2021: in an email of that date to Welsh government colleagues, Dr Davis reported the view that *“the consensus view of the cell was that the IPC guidance as it stands was currently fit for purpose. There was no evidence that the mode of transmission of the virus had changed”* [INQ000252535_0002]. The group is concerned to understand whether PHW did, or not did, advise the Welsh Government on route of transmission, and why there is confusion over this position. The group understands that the Inquiry had limited time and resources available, but nevertheless considers it was a missed opportunity to explore this important issue – in so far as it related to PPE - with a witness from PHW.

Evidence that IPC guidance was driven by resource/constraints in supply

98) Secondly, there are serious concerns as to why IPC guidance sought to limit the use of FFP3s, in particular, the extent to which IPC guidance was driven by supply/resource

constraints, rather than the health and safety of healthcare workers and patients. It is well known that FFP3s cost much more per unit than fluid resistant facial masks (Type IIR masks): in Wales, the average unit price for FFP3 ranged between 10 to 110 times the average unit price of Type IIR masks over the period November 2019 to October 2020 (calculations based on data from NWSSP summarised in the report of John Manners-Bell [INQ000474864 at §329; Table 3]). Plainly, the issues with supply and resourcing impacted the IPC guidance:

- a) Professor Jonathan Van Tam acknowledged in an email to the HSE on 23 January 2020 regarding appropriate levels of PPE that, whilst the maximum level Respiratory Protective Equipment was required: *“this was neither affordable nor practical for pandemic stockpiling”* [INQ000151353]. And on 20 March 2020 Professor Van Tam called for, *“a proportional plan for sensible prioritised use of what PPE we have and can get. In other words, given the science, given the reality of stocks, how can this be prioritised in the most sensible, risk-stratified way”* [INQ000381179].
- b) Professor Catherine Noakes explained the reluctance to properly acknowledge airborne transmission, despite a growing evidence base, as (in part) a result of *“the significant resource and operational implications it would have for hospital infection control measures...”* [INQ000236261].
- c) Dr Claas Kirchelle explained that cost-cutting considerations *“dominated”* decisions in respect of critical PPE, particularly FFP3s [INQ000205178_0090-92].
- d) Specialist Practitioner Laura Imrie, a member of the IPC cell who gave evidence on behalf of Antimicrobial Resistance and Healthcare Associated Infection (**ARHAI**) in Scotland, said that *“if we wrote guidance as a precautionary principle to put everybody into FFP3 then not only would they have had a large amount of the workforce that couldn't comply with the guidance, and therefore couldn't come to work, we would also have had high risk areas...that might have been left without the FFP3s...there was at the beginning of the pandemic a very quick and a rapid stocktake of what stock we held and what was required, and from my understanding that would have made it really difficult to supply the FFP3s to ITU units and other areas we deemed high risk”* [05.11.2024/149:17 – 05.11.2024/150:8].

99) Such concerns were felt on the ground, at local authority level in Wales. Dr Chris Llewelyn, Chief Executive of the WLGA observed in his witness statement that:

“local authorities were uncertain what to purchase and at what scale — it appeared that guidance was driven by what was available on the market rather than by products which were fit for purpose or achieved the conditions to limit the spread and impact of Covid-19” [INQ000518355_0015 at §33].

- 100) A briefing note from Chris Jones, DCMO for Wales, dated 13 January 2021 confirmed that:

“FFP3 masks are relatively challenging to procure, certainly global production would not be sufficient to meet an increase in demand” and “UK IP&C guidance must be followed across the UK and that to allow the wider use of FFP3 masks would not only be inconsistent with the evidence, but also threaten the availability of such items for areas where they are evidence based and effective e.g. ITUs” [INQ000473726].

- 101) Thus, the CBFJ Cymru remain concerned that, as far as IPC guidance is concerned, the emerging picture is one of supply-led guidance, rather than guidance-led supply. Given guidance determined the procurement strategy, the result is that many healthcare workers in Wales were given a level of PPE insufficient to protect them, and their patients, from the virus. And this was so notwithstanding the growing body of evidence that the virus was spread by aerosol transmission from the early stages of the pandemic.

- 102) The real impact of IPC guidance on PPE is best understood with examples from people’s day to day experiences during the pandemic. Two such examples of appear below:

- a) Alan Haigh was an emergency technician for the Welsh Ambulance Service. In February 2021, he attended a patient’s home and caught covid. His colleague, Ms Cadi told an Inquest that the Mr Haigh was wearing level 2 PPE. This comprised a mask, gloves and apron, and was the level of protection issued to staff for routine patients. Ms Cadi herself wore level 3 PPE, as she administered the treatment. Both acted in accordance with guidance. Clearly, Mr Haigh’s level of PPE was not sufficient to protect him, and he passed away from covid.
- b) A locally employed doctor told the BMA *“I was redeployed to ICU [Intensive Care Unit] part way through from AMU [Acute Medicine Unit]. The difference in protection was stark. In ICU we had full PPE for anyone suspected and were told by consultants to take our own PPE to any ward patients to protect*

ourselves [...] On the AMU side, even though there is an undifferentiated take, self bought masks were not permitted (as they would frighten patients!) until a while after the CDC [Centres for Disease Control and Prevention] and WHO [World Health Organisation] recommendations were made. It was clear that ICU was prioritised and wards were having other 'guidance' to protect PPE levels. This is not equity, and judging by the level of staff COVID sickness in wards compared to ICU, and patient breakouts, there are indicators that staff and patients came to harm during this time due to these differences" (witness statement of Professor Philip Banfield on behalf of the British Medical Association [INQ000562457_0018] at §58).

Conclusion

- 103) Whilst the CBFJ Cymru is aware the IPC guidance was considered in a previous module, the group urges the Inquiry to address the issue afresh in the context of the cross-cutting issue of adequacy of PPE supply. Professor Catherine Noakes, from whom the Inquiry heard in 2023 explained the reluctance to properly acknowledge airborne transmission was in part because of *"the significant resource and operational implications"* of doing so. Consistent with that, the Audit Wales report put the cost of an FFP3 mask at 110 times the cost of a fluid resistant mask during the pandemic (October 2020). If supply shaped the IPC guidance, as many in the group fear, then no amount of analysis about PPE supply chains and distribution channels would assist in a future pandemic. What matters is that the appropriate PPE – offering the appropriate level of protection – is supplied.
- 104) It is a matter of very great concern to CBFJ Cymru that the IPC guidance should have been used as a means of rationing the procurement and provision of FFP3 respirators. While it is recognised that, due to inadequate preparation and planning, there were insufficient quantities of FFP3 stocks in the early months of the pandemic, with no immediate means of procuring adequate stocks, this does not excuse the failure of the IPC guidance to recommend that FFP3 (or at least some other form of RPE) was required to be used when treating patients with (or suspected to have) Covid-19. This inappropriate use of IPC guidance had the following consequences:
- a) It failed to inform healthcare professionals of the risks they were exposed to in the workplace, by inaccurately advising that surgical masks (that do not protect against airborne infection and are not even classed as PPE) were appropriate protection against a deadly airborne virus.

- b) It undoubtedly contributed to the high levels of nosocomial infections in hospitals and care homes, including to patients and healthcare professionals.
- c) It artificially suppressed the level of use of FFP3 masks and produced false levels of demand against which procurement was based (inaccurately).
- d) Once world-wide demand for PPE eased in the summer of 2020, which provided an opportunity to procure enough FFP3 masks in preparation for the inevitable second wave (which proved to be more deadly than the first), this opportunity was squandered because only sufficient quantities of FFP3 masks for use in IPC settings and AGP procedures were purchased (in accordance with the flawed advice in the IPC guidance) rather than the quantities needed to protect healthcare workers and patients in more general settings.

LESSONS LEARNED

Introduction

- 105) After some introductory remarks, this section on lessons learned considers lessons learned from:
- a) The Rt Hon. Mark Drakeford
 - b) Mr Vaughan Gething
 - c) Witness who gave oral evidence: Mr Brace, Mr Slade, Mr Irvine Mr Davis.
- 106) The Inquiry will make recommendations regarding the procurement and distribution to end-users across the four nations of the United Kingdom of key healthcare related equipment and supplies, including PPE, ventilators and oxygen (Final List of Issues; Outline of Scope).
- 107) The CBFJ Cymru urges the Inquiry to approach the recommendations and/or lessons learned offered by witnesses from the Welsh Government or its “arms-length” bodies with caution. The group observes that the tenor of lessons learned regrettably appears to be one of self-congratulation. Far from offering constructive criticism of Wales’ performance in the area of procurement and distribution of PPE and key equipment, which would benefit future generations in the event of a future pandemic, their emphasis has been on Wales’ success in procurement of PPE and equipment.
- 108) Of course, the CBFJ Cymru does not seek to undermine the hard work of many during the pandemic. Nor does it seek to minimise success where it is evidenced (that,

too, would do a disservice to future generations in the event of another pandemic). However, the group observed (what appeared to be) a reluctance to admit problems in Wales and a readiness to attribute the cause of problems to others (typically the UK Government) or to systems and structures beyond their control (poor levels of UK manufacturing, failures in the global supply chain).

- 109) This is not a concern levelled at one or two witness statements or witnesses. This is a concern levelled at the vast majority of those who have provided evidence, whether written or oral, on this topic for Wales. It is for this reason that the group seeks to emphasise this point to the Inquiry. The official position (for that is what it appears to be) that Wales, after overcoming some initial difficulties, got things right and managed things much better than other parts of the UK, is so widespread that it represents an entrenched culture of belief. This culture is epitomised by leadership of the Welsh Government during the pandemic: the Rt Hon Mark Drakeford and Mr Vaughan Gething, whose “lessons learned” are considered below.

Lessons Learned: the Rt Hon Mark Drakeford

- 110) Mark Drakeford has provided a witness statement in Module 5 [INQ000528293] at the conclusion of which he sets out his reflections and lessons learned [INQ000528293_0019 to 0021; §§80-91]. The Inquiry will find no assistance there in understanding why those in Wales did not have appropriate or adequate supplies of PPE and equipment and how such problems could be avoided in the future. It is devoid of critical reflection on Wales. Instead, the reflections comprise statements highlighting Wales successes and/or the UK Government’s failures. We set out a few salient examples below:

- a) In relation to procurement processes, Mr Drakeford reflected “the procurement processes in Wales, were robust, effective and transparent” [INQ000528293_0019 at §80]. This is inaccurate. Not a single PPE contract scrutinised by Audit Wales was published in accordance with required procurement practice [INQxxx].
- b) In relation to procurement, Mr Drakeford reflected “the success of the procurement of PPE in Wales was facilitated by the crucial early decision for a Barnett allocation of funding to Wales, rather than funding from a centralised UK pot”. Talk of “the success of the procurement of PPE” is vague and inaccurate: what is the “success” to which he refers, when so many, for much

of the pandemic, did not have appropriate and sufficient PPE and healthcare equipment?

- c) In relation to the amount of UK funding, Mr Drakeford said “I do not believe there were any issues with regards to the quantity of funding made available for the procurement of PPE and other key healthcare equipment in Wales”. The UK Government allocated Wales £1.022 billion for PPE procurement. The Welsh Government managed to spend only £385 million (Slade [14/3/25; 14/74/15]). The question for many is why the Welsh Government spent only one third of what was available on PPE, when so many went without? And where did the rest of the budget allocated to PPE go?
- d) In relation to distribution, Mr Drakeford cited the “valuable assistance of the military to review distribution arrangements.” [INQ000528293_0019 at §81]. Their review may indeed have been valuable. But it was a one-week review in April 2020, which highlighted that Wales had no handle on stock levels. Distribution remained a problem throughout 2020 and into 2021. Mr Drakeford offers no reflection on why this occurred or how it could be prevented in future.
- e) In relation to supply chain issues, Mr Drakeford said there was a need to invest in domestic supply chains and there should be an “articulated industrial strategy from the UK Government”. Few would disagree that serious consideration must be given to the resilience of domestic supply chains. But here, in typical fashion, Mr Drakeford’s lesson is not for Wales, but for those “particularly within HM Treasury” and the UK Government. The lack of “overall direction or a playbook” for Welsh manufacturers during the pandemic was not the fault of the Welsh government, but Westminster.
- f) In relation to integrity of supply processes, Mr Drakeford raised (unspecified) concerns about the “integrity of processes run by the UK government in securing domestic supplies” only to praise the standards of integrity in Wales. Such reflections are vague and unsubstantiated. Whatever the truth of the standards that were applied in Wales, they did not translate to the adequate and appropriate supply of PPE and equipment to those who needed it most.

Lessons Learned: Mr Vaughan Gething

- 111) Mr Gething has made a statement for this module in which he sets out some lessons learned [INQ000536418]. As with Mr Drakeford, the Inquiry will find no assistance there in understanding why those in Wales did not have appropriate or adequate supplies of PPE and equipment and how such problems could be avoided

in the future. For, like Mr Drakeford, Mr Gething's lessons learned are devoid of critical reflection on Wales.

112) Remarkably, for someone who was the Minister of Health and Social Services, his collection of 'lessons learned' totalled just 300 words, most of which reveal an unwillingness or inability to engage with issues of substance. His "key reflections and lessons" include:

- a) "How quickly stores of supplies, in particular PPE, can be exhausted during a pandemic, or similar event of this magnitude...";
- b) "The need for broad political and public support if we are to seriously invest in improving the resilience of domestic supply chains...";
- c) "The importance of mutual aid between the four nations..."
- d) "We should expect a future pandemic to distress national and local supply chains as happened here..."

113) Beyond the statements of the obvious set out above, Mr Gething promotes the Welsh success story seen in Mr Drakeford's lessons learned. Further reflections noted: "The importance of a central purchasing and procurement system which focused on both quality and value for money and, crucially, did so in a fair and transparent way, without preferential treatment." Undoubtedly, a reference to the NWSSP, but a reference lacking any substance. This utopic vision of the Welsh PPE procurement system is betrayed by the facts:

- a) the 'call to arms' to Welsh manufacturers to assist with PPE was late: it came on 20 April 2020, well after the shortages on the frontline were being reported [see e.g. concerns raised with the Welsh Government of 22 March 2020 – INQ000395479_0005];
- b) PPE was substandard [Slade; 14/70/7]
- c) Procurement lacked transparency [Audit Wales report 2021; INQ000214235]
- d) And, most importantly, the system did not deliver. Those who needed PPE and equipment did not have it, particularly in the care sector.

Lessons Learned: other witnesses from Wales

114) As to lessons learned from those who gave evidence, the tenor is the same.

115) Mr Brace was asked about his lessons learned. He referred to the Audit Wales report: "*I think the Wales Audit Office report I'd fully agree with their insight and their*

recommendations for the future, so I won't repeat those" [Brace; 6/194/2]. In fact, the only criticism in that report was the lack of transparency in procurement contracts, so that lesson learned does not assist very much. The Audit Wales report was an overwhelmingly positive assessment. Mr Brace also felt better planning was needed, but did not elaborate on this further, save to say:

"I've always believed that plans are great but it's people that makes plans work, and we were really fortunate in Wales to have some very experienced procurement professionals sitting within an organisation that had central responsibility for buying, storing, distributing, and fairly sort of joined-up established relationships, and I think they were critical particularly in that phase of the pandemic" [Brace; 6/194/14].

- 116) Mr Brace praised "small governance" - which translated to an ability to get ministerial approval quickly and put in place actions really quickly [Brace; 6/194/15-6/195/17]. But small governance did not translate to provision of adequate PPE and equipment to hospitals and care homes, and to that extent small governance did not assist.
- 117) Mr Slade said "there are definitely lessons that we can learn at a local level" [Slade; 14/86/14] but did not elaborate. Unlike the chief executive of the WLGA, he had no concerns about the Welsh Government's appetite to work collectively and inclusively with those at a local level.
- 118) Mr Irvine spoke to the need for resilience in the supply chain: a lesson with which few would disagree. He could not help with lessons to be learned on distribution – that was not the concern of NWSSP. As he put it "the more important issue here is to understand what the responsibilities of my organisation are and where they started and where they ended" [Irvine; 14/155/13-14/156/8].
- 119) And finally, Mr Davis spoke of his lessons learned: "*Governments need arms-length bodies and vice versa to ensure truth is brought to power based on sound information and intelligence.*" [Davis; 14/181/10]. As to what that meant in practice – what truth was brought to Welsh ministers during the pandemic by CERET - he said that was "*out of the scope of my role as CERET.*" [Davis; 14/181/17]. Regrettably, the group and the Inquiry are none the wiser.

120) Mr Davis reflected that CERET was a success since, “*Wales never ran out of equipment*” [Davis; 14/169/23] but this claim was not scrutinised and the lived experience of many members of the group would cause them to doubt its accuracy.

121) In summary, the group wishes to record its disappointment that the lessons learned from Welsh leadership and those in positions of responsibility appear to demonstrate little critical analysis about what went wrong in Wales. Those that did give evidence seemed more determined to defend the decisions they took than explore ways in which things could have been done better and thus to learn lessons for the future.

CONCLUSION

122) Just four witnesses gave evidence from Wales. Much of their evidence was dedicated to the technical and procedural aspects of procurement. But for the members of the CBFJ Cymru, the concern has always been to understand why those that needed PPE and equipment such as ventilators and CPAPs did not have it. In opening, the group asked why there were such shortages of PPE, why access to ventilators and equipment was inadequate, why the risk of nosocomial infection was so high in Wales, why care homes were overlooked, whether shortage in supply of FFP3 masks influenced IPC guidance, such that healthcare workers were inadequately protected. These questions, regrettably, remain unanswered. Gaps remain. And if gaps remain, and questions remain unanswered, there is of course a real concern that the Welsh Government have not learned lessons for the future.

Covid-19 Bereaved Families for Justice Cymru

6 May 2025

Module 6 of the UK Covid-19 Inquiry

Written closing statement on behalf of the Covid-19 Bereaved Families for Justice Cymru (CBFJC)

Introduction

1. Care homes were one of the least safe settings in Wales during the pandemic, and residents were extremely vulnerable - excess deaths during waves 1 and 2 were approximately 100% and the research of Professor Shallcross and colleagues established that once residents became infected in wave one, there was a 36% chance that they would die [INQ000544928_0001].
2. This vulnerability was well known to the Welsh Government (WG). However, despite this knowledge, elderly people in Wales were neglected. Worse, the claims that WG prioritised elderly people is not supported by their actions, as demonstrated throughout this statement.
3. False claims have been made by WG in connection with their testing policy. In their oral closing statement to Module 6, WG state that it was scientific and medical advice that prevented sooner testing on discharge from hospital to care homes [Day 20/125:18] and, *“that decisions on asymptomatic testing were similarly based on scientific advice available at the time and not based on testing capacity”* [Day 20/126:3-5]. This is not the case. It was a lack of testing capacity and concerns about the impact on staff absences that prevented more widespread testing. Further, CBFJC’s closing statement will demonstrate how WG consistently used, ‘the science’, both during the pandemic and at the Inquiry, as a ploy to evade challenge and accountability.
4. This closing statement is divided into four parts: testing failures; inadequate IPC and PPE; the de-prioritisation of elderly people; and the failure to prepare for the second wave.

First - testing failures

5. Testing decisions and policy in Wales were slow, dysfunctional, reactionary, and false statements were made to justify not implementing testing sooner.
6. Emails from Care Inspectorate Wales (CIW) following a meeting with WG on 22 April 2020 record that *“testing arrangements are fragmented and differ across Wales”*, there is *“no central lead for testing”*, and *“no one could answer the question who or what organisation is in charge”* [INQ000198307]. Similarly, Professor Khaw confirmed during his evidence that there was a disconnect between Public Health Wales (PHW) and WG at the end of April around some of the decisions [Day 6/144:19-21].
7. The WG’s position on testing at the Inquiry has two key features. First, that the risk of discharging untested patients into care homes did not come to the fore until 15 April [Module 7 Day 1/124: 7-9]. Second, that it was not until 12 May that the balance tipped

in favour of a programme of testing asymptomatic care home residents and staff [Module 7 Day 12/164:3-8]. The WG maintains that scientific and medical advice precluded earlier testing in both these areas, as follows, "*General asymptomatic testing in care homes was not introduced before 16 May because the advice received up to that point by the Welsh Government was that the scientific evidence did not support it. You also heard in evidence that the advice relating to asymptomatic testing of all care home residents that was referred to by Matt Hancock in a Health Minister's meeting on 5 May 2020 was never shared with the Welsh Government at any level nor were its contents reflected in SAGE advice at that time*" [Day 20/126:12-21]. CBFJC submits that these positions and statements are false. Scientific evidence (including advice from SAGE) did not support WG's position, and there was widespread sharing of information between the UK Government and WG.

8. Testing on discharge and routinely in care homes was required because of the vulnerability of care home residents and the risk of asymptomatic transmission. In Module 7 Professors Fraser and Nurse told the Inquiry that the evidence of asymptomatic transmission "*emerged quite clearly throughout February and March 2020*" [Module 7, Day 2/199:19-20] through studies from China, Hong Kong, Italy, and the cruise ship Diamond Princess [Module 7, Day 4/32:16-19]. And Professor Harries said that, "*...asymptomatic testing and the risks were completely understood, I think, in March...there was a particular study in the US, in the Seattle care home [INQ000224063], which gave a lot of strong evidence with very good data and denominator factors of asymptomatic transmission, and then PHE actually did what's known as an Easter 6 study [INQ000320602], in the Easter weekend, which gave us...home grown UK figures for the first time, which were really robust...*" [Module 7, Day 10/142:6-18].
9. This evidence was not hidden from WG - it was publicly available and well understood. And it is clear that the First Minister, Mark Drakeford, was aware of the dangers to care home residents from statements made in the Senedd in March 2020: on 3 March 2020, "*...what we know about the virus is that its impact is more significant amongst older people and people's whose immune systems are already compromised because of other conditions. And those people are to be found in greater concentrations in residential and nursing homes*" [INQ000321248_0012]; and again on 24 March 2020, when Mr Drakeford warned, "*...most people will experience a very mild episode of this illness...The problem is that while you are asymptomatic you could be passing the virus on to somebody who is much more vulnerable*" [INQ000420992_0020].
10. Given the extreme vulnerability of care home residents to Covid-19 infection, a proper precautionary approach demanded asymptomatic testing both on discharge from hospital, and routinely within care homes, at the earliest opportunity.
11. The WG decided against this precautionary approach and chose to prioritise what little

testing capacity it had elsewhere. But rather than own and explain this decision at the Inquiry, they have hidden behind ‘the science’.

12. 1,088 patients were discharged from hospital into care homes in Wales, prior to the introduction of testing on discharge on 29 April 2020 [INQ000271757_0008], which seeded infections into vulnerable communities. The extent of this practice goes beyond the failure to identify asymptomatic infections and includes knowingly transferring patients, who had either tested positive or were suspected to be infected with Covid-19, into care homes, raising ethical issues, such as:
 - a. The circumstances explained by the CBFJC impact witness, Alison Sibley [INQ000614374], whose mother, Rosalind Brockbank, was admitted to hospital on 4 March 2020 following a fall, and while there acquired and tested positive for Covid-19. Despite continuing to exhibit symptoms of Covid, and a physiotherapist recording in her medical notes that she was not fit for discharge, she was nevertheless transferred to a residential care home without a further test. She died from Covid-19 on 17 April 2020 after 11 days of deterioration following her discharge from hospital.
 - b. An email exchange between the Association of Directors of Social Services Cymru (ADSS Cymru) and Swansea Council on 14 April 2020 [INQ000511731]: *“Swansea have experienced: 1) Discharge to dom care where we weren't informed that patient had been tested. Subsequent result of test was positive. Was back before we had much of a grip on PPE. Risked infection of a number of staff and other care recipients. 8 staff ended up in isolation. 2) Patient discharged to a care home. Were tested as positive. Not symptomatic. Care home weren't aware until after the individual died and GP turned up in space suit saying that they could see on the records that the individual was positive for covid infection...Having a meeting about the ethics of knowingly transferring infection into a care home setting later this week”*.
 - c. Email correspondence between Care Forum Wales (CFW) and WG on 2 March 2020 proposing to *“facilitate faster discharge from hospital and the use of care home beds to free up space in our hospitals...”* [INQ000183761].
 - d. Concerns expressed by CIW to WG on 8 April 2020 in relation to proposed guidance advising and encouraging care homes to accept patients from hospital including those that might have Covid-19 whether symptomatic or asymptomatic, and querying how care homes could safely care for patients with Covid-19 and protect the other people living in the home [INQ000198288].
13. In respect of routine testing, WG refused to accept the need for routine testing in care homes to combat widespread asymptomatic transmission, despite a wealth of published scientific evidence by the end of March/early April 2020 that significant asymptomatic transmission was occurring (to which care home residents were particularly susceptible

and vulnerable). The UK Government was slow to respond to this risk but did at least recognise it by 14 April 2020 within GO-Science advice of this date that confirmed that asymptomatic infection “*is common and represents a large proportion of disease transmission...Intensive track-and-trace testing efforts, including of asymptomatic individuals, are thought to be core to the successful disease control efforts in South Korea, Hong Kong, and Singapore...*” [INQ000087177_0001-2]. The UK Government went on to announce routine testing for care home residents and staff on 28 April 2020 (almost three weeks before WG, which delayed until 16 May).

14. Meanwhile in Wales, WG tied itself in knots trying to justify its lack of action, and the former First Minister, Mark Drakeford, made false statements in the Senedd when claiming on 29 April and 6 May 2020 that there was no clinical value in routine asymptomatic testing in care homes. On 16 May 2020, WG finally changed its position and announced routine testing in all care homes. However, this did not take place immediately and was of a one-off nature for residents. It was completed by mid-June 2020, but only after the huge loss of life experienced in Wave 1.
15. The WG claims that this change of approach could not have been taken prior to 12 May 2020 when ‘new’ advice was provided within the meeting and minutes of SAGE 35 that, “*extensive testing of both residents and staff is **crucial** [emphasis added] both in care homes which have reported cases and those which have not*” [INQ000215622_0002]. But this was not new advice at all. SAGE meeting minutes from 14 April 2020 repeatedly warned of significant transmission in hospitals and care homes and the need for increased testing in these settings. For example, at §11 of the minutes of SAGE 25 on 14 April 2020, “*SAGE advises that increased testing in these settings, supported by modelling, is important*”. Further examples at SAGE 26, 28, 29, 30, 33, and 34 can be found within CBFJC’s written closing statement to Module 7 at §51. The real reason that the WG introduced routine testing following SAGE 35 was not because the SAGE advice was new, but because it had become completely untenable to perpetuate further WG’s false claim that there was no clinical value in asymptomatic testing.
16. It was blindingly obvious to those on the frontline from early in the pandemic that routine testing was needed in order to prevent and control transmission in care homes. The Inquiry heard from Helen Hough, the owner of a care home in North Wales, about its importance and her efforts to secure testing, including within her email to her assembly member and the Minister for Rural Affairs and North Wales on 1 May 2020 (which Ms Hough requested be shared with Mark Drakeford and Vaughan Gething): “*...without anyone being tested, we do not know who has it, and who does not, so the risk of transmission is exceptionally high, especially as we are discovering with this very new disease that people can be asymptomatic but still test positive, therefore we do not know who is carrying this into the building, and that is why COVID-19 is ‘spreading like wild fire’*”

in Care Homes...I do not know how long it is going to be before relatives of the deceased speak to one another and realise they are not being treated with the same importance as England (less than 9 miles from here) and as the Prime Minister of the UK want them to be treated. Relatives are assuming these tests are being carried out as they see it on their national news...and [would] be horrified to learn that the Welsh Government has decided it's not important enough" [INQ000598470].

17. Testing capacity in Wales in mid-March was just 500 tests per day across the whole country and only 15 tests per day were available to Welsh local authorities with which to test their social care staff [INQ000569773_0092]. By April, capacity had increased marginally to 1,000 tests per day on 9 April 2020 [INQ000312371_0002], 1,800 tests per day as at 20 April 2020 [INQ000253584_0001], and 2,100 tests per day by 29 April 2020 [INQ000501510_0003]. This lack of capacity was the real reason testing could not be introduced sooner and blaming scientific uncertainty is simply a convenient means of avoiding responsibility. This cynical approach is now clearly exposed at the Inquiry by the following evidence (set out chronologically).
18. Within the witness statement of Albert Heaney, it is stated at §309, *"I, along with policy colleagues in my directorate, was concerned at the conflict between expediting hospital discharge to create capacity, and potential risks arising by returning or placing people vulnerable to the effects of Covid-19 back into care homes. This was a very difficult situation where decisions could only be taken by considering what was known at the time. It was clear that if discharges were not made, hospitals would not be able to function effectively which would inevitably lead to increased deaths. In the absence of advice to the contrary from health experts, the Deputy Chief Medical Officer (Wales), Public Health Wales, and evidence regarding the possibility of asymptomatic transmission; while testing of all patients upon discharge would have been preferred, without sufficient testing capacity it was not possible"* [INQ000551798_0088-89]. Despite this clear and detailed account of Mr Heaney's wish to introduce testing on discharge but for a lack of capacity, Mr Heaney resiled from this position in his oral evidence to the Inquiry on 15 July 2025. While confirming that the capacity to undertake *"wider-base testing"* did not exist until May and June 2020, Mr Heaney explained that in fact the decision that he made on 8 April 2020 not to test all patients on discharge from hospital to care homes was based on *"medical and scientific advice"* and that the statement to the contrary made within his witness statement at §309 (quoted above) was Mr Heaney's view, *"in hindsight"* [Day 10/139:1-140:17]. While not doubting the sincerity of Mr Heaney's concern, CBFJC does not accept this explanation, and the attempt to reconcile the statement, *"...while testing of all patients upon discharge would have been preferred, without sufficient testing capacity it was not possible"* with the position of WG at the Inquiry that they were following the science, is not credible.

19. The preliminary findings of the Public Health England (PHE) Easter 6 study was shared with the UK Senior Clinicians Group (which included the Welsh CMO, Sir Frank Atherton and DCMO, Dr Chris Jones) “as soon as these were available, in the week commencing 13 April 2020” [INQ000309002_0023]. The PHE report of this study, titled, “The Easter 6 Care Home Investigation” [INQ000320602] found that of the 218 residents, 107 (49.1%) were SARS-COV-2 positive of whom 51 (47.7%) did not develop any symptoms during the two weeks before or after swabbing. 20% of the staff tested positive, of whom only approximately 20% were symptomatic.
20. Shortly after this meeting, on 15 April 2020, an email was sent from WG to PHW that stated, “Just to alert you that CMO and Albert Heaney want a revised approach to testing in place asap which will include testing on hospital discharge to care homes and more general testing for care home residents and staff” [INQ000520929]. CBFJC suggest that this request for testing on discharge and more generally in care homes was likely in response to the GO-Science report of 14 April and the PHE Easter 6 study.
21. The 15 April email was followed by an email exchange between WG and PHW on 16 April 2020 [INQ000598625] which states, “CMO and Albert Heaney want a revised approach to testing in place asap which will include testing on hospital discharge to care homes and more general testing for care home residents and staff. They wish to communicate this tomorrow. As you can see from the numbers below there does need to be a significant increase in testing capacity to deliver on this given the commitment already given to LRFs to test key workers. Can you confirm that PHW are on track to deliver 2207 tests as of Monday 20th?” To which, PHW replied, “We are working to clarify our testing capacity, which is increasing sequentially over the next days and weeks...I’m not sure that there will be a significant mismatch between demand and capacity”.
22. PHW interpreted the WG emails of 15 and 16 April 2020 as, “the Welsh Government’s Social Care colleagues were relaying a message from the CMO and Albert Heaney, that they wished to write out to care homes and advise that Wales would also be testing patients prior to discharge and testing all symptomatic residents in care homes...[however] we still had not had any discussion with the CMO about this proposed change” [INQ000587702_0057]. Further, Giri Shanker of PHW replied to Alison Machon (WG Head of Regulation and Inspection Policy) on 16 April 2020, as follows, “I have not been involved in any discussions with CMO on this...I want to be very clear that (1) Just because PHE have changed their guidance, it does not mean we have to (2) If we were to follow the English guidance, **we certainly do not have the testing capacity to meet the revised requirement** [emphasis added]” [INQ000617081].
23. At §203 of Professor Khaw’s statement [INQ000587702_0057], it is stated, “Andrew Jones from Public Health Wales had also attended a meeting with the then Minister for Health and Social Care and Local Authority Leaders on 16 April 2020, where the Minister

for Health and Social Care presented a different position on testing based on CMO advice". This account is corroborated by the email of CIW of 16 April 2020 [INQ000501494] in which Gillian Baranski, the Chief Inspector, expressed her concern at Mr Gething's comments, "*Hello Frank, I was at a meeting earlier today with the leaders of local government and Vaughan Gething. Covid 19 testing for people discharged from hospital back to care homes was the main focus of the discussion which became quite heated. The Minister insisted repeatedly he was following your advice as CMO that asymptomatic people did not need testing before being released to care homes. There was much consternation expressed by the leaders of local government and I imagine there will be further and repeated discussion about this going forward. You will be aware of discussions we had last week with PHW colleagues when we voiced our significant concerns about this. We are aware that in England they will shortly be testing everyone released from hospitals to care homes (both symptomatic and asymptomatic)*". Either the CMO was instructing PHW to introduce testing on discharge while simultaneously advising Mr Gething that there was no need to do so, or Mr Gething had misrepresented the position. There is no witness statement from Sir Frank Atherton in Module 6, and his statement in Module 7 is noticeably silent on the issue of asymptomatic transmission over this crucial period.

24. An email between Mr Gething and Dr Rob Orford (Chief Scientific Advisor for Health) over the course of 16 April to just past midnight on 17 April 2020, to which Sir Fank Atherton was copied [INQ000530887], makes clear that Mr Gething knew that testing on discharge from hospital was being prevented because of a lack of testing capacity and not by reason of scientific and medical advice. Within this chain, Mr Gething states, "*I want clarity and an explanation about where we are, where we expect to be this week and at the end of next week. I will go out and do the public explaining but at this point I haven't been told why we had commitments that we cannot meet and I do not have a sustainable position to offer on increasing capacity and usage*" [INQ000530887_0005]. Mr Gething also specifically requested an explanation of, "*...the plan expected to deliver and when in April*", and for care home testing of staff and residents and the testing of care home residents on release from hospital to be added to the testing review [INQ000530887_0001]. Dr Orford's replies within the chain include notification of the extremely high rate of Covid-19 positivity within care home residents and workers (from what little testing was taking place in Wales) at 48% and 52.5%, respectively [INQ000530887_0003], and that Wales had managed to perform 1,000 tests on 15 April 2020 [INQ000530887_0004].
25. On 17 April 2020, Dr Orford provided a briefing note to Mr Gething [INQ000384410] that contains the following statements: "*Testing to tell you have coronavirus if you have the symptoms of COVID-19 is not that helpful, **unless you work with vulnerable people or***

patients [emphasis added]" [INQ000384410_0001-2]; *"In order of priority and areas of greatest need for testing are (1) Testing in healthcare and social care settings to reduce harm"* [INQ000384410_0002]; *"We know that we have [to] test more people in the healthcare setting, patients and staff alike as well as in the social care setting both residents and social care workers where greater harm may arise from infection"* [INQ000384410_0002]; *"Our initial plan to deliver five thousand tests a day has been hit by global supply chain issues...Two weeks ago, I committed further monies, to bring in further equipment and reagents to increase our testing capacity. We have not announced the additional tests per day that this will bring us as the media will crucify us again if we are late by a week...We have deliberately made different decisions about mass testing than others"* [INQ000384410_0003].

26. On 18 April 2020 PHW met with PHE to discuss the results of the Easter 6 study, a note of which meeting is at INQ000191663. Later that day, PHW held their own separate meeting to discuss ideas for a Wales approach and produced a note of this meeting [INQ000384504] that includes the following statements: *"COVID-19 has proved highly infectious in closed settings...once 3 or more cases are reported, there is around 50% prevalence in both staff and residents despite apparent use of PPE...most care homes will become affected over the next 6 weeks...There is also evidence of underreporting in deaths and of a rise in deaths in the care home setting...Possible measures to consider include: Prevention of entry into the home and more testing in staff, including asymptomatic"*. This note was shared with the WG immediately (such was its significance) and prompted the drafting of Ministerial Advice.
27. Within an email chain over 17 to 19 April 2020 [INQ000384521], the following statements are made. On 17 April 2020, WG instructs that *"NHS Wales and PHW in support of the prevention and management of COVID-19 in care homes will provide the following: (1) Discharge testing to all patients being transferred from secondary care to care homes...(3) Rapid response to care homes who report possible case or cases...In support of the above PHW are requested to provide a brief paper on the mechanisms by which both staff and care homes will have access to prompt testing and support"* [INQ000384521_0004]. Then on 19 April 2020, Andrew Jones of PHW emailed WG colleagues, stating, *"clearly there are requirements of HBs and trusts e.g. in relation to patient testing prior to discharge and in using CTUs for testing of care home staff"* [INQ000384521_0002]. To which Dr Gillian Richardson (then Professional Advisor to the CMO) responded later on 19 April 2020 to PHW and WG colleagues, *"There have been 2 meetings also with England on Care Homes yesterday and one scheduled today which Chris Williams is attending from PHW. The situation is one which is rapidly emerging, as we now know that most Care Home infections are occurring through Staff. Where 2 resident infections occur in fact usually half of staff will have had Covid19 (many*

- asymptomatic*). Enclosing the meeting notes. Expect guidance will be issued formally soon". The two documents attached to this email chain are believed to be the note of the PHE/PHW discussion on 18 April 2020 [INQ000191663], and the note of the subsequent PHW meeting, also on 18 April 2020 [INQ000384504].
28. PHW produced a proposal for the management of Covid-19 in care homes on 20 April 2020 [INQ000520962]. This document includes the following statements, "*It is clear from experience within the enclosed settings cell and from recently completed epidemiological investigations in England that infection is widespread within care settings and that transmission within the settings is rapid and difficult to contain. Rapid, proactive and consistent action is required as soon as the first symptomatic case is identified. **Even in these circumstances the level of infection may already be significant among asymptomatic individuals*** [emphasis added]" [INQ000520962_0002].
 29. On 20 April 2020 there was a Senior Clinicians Group Meeting, for which a PHE paper of the same date on the prevention of Covid-19 in care homes was circulated (including to Sir Frank Atherton). The paper states, "*By the time an outbreak is reported, the SARS-CoV-2 infection can be widespread in the home...Modelling suggests that the key vehicle for the spread is the movement of care home staff...public health advice is only likely to have a small impact during an outbreak and there may be greater benefits in supporting care homes to prevent introduction*" [INQ000348275_0005]. The paper lists potential measures in response including, an occupational health screening/testing for asymptomatic staff on a regular basis to pick up asymptomatic positive staff early and exclude them [INQ000348275_0007, and 0009].
 30. At a meeting with Albert Heaney on 23 April 2020, Directors of Social Services queried when testing on discharge and asymptomatic testing of care home residents and staff would be implemented. CIW indicated that they wished to see these actions as soon as possible [INQ000198308].
 31. On 23 April 2020 there was a Senior Clinicians meeting attended by the Chief and Deputy Medical Officers and Chief Nursing Officers from across the UK, including Sir Frank Atherton (Welsh CMO), Dr Chris Jones (Welsh DCMO), and Jean White (Welsh CNO). The minutes [INQ000068951] record an update on care homes that included the following statements by Paul Johnstone of PHE, "*There is a lot of asymptomatic transmission in care homes...Review of international evidence identifies effective actions including hand hygiene; environmental decontamination; staff rotation with staff allocated to one facility consistently; testing of care home residents and staff...symptoms are not good indicators of cases in elderly/care home residents*" [INQ000068951_0002]. The update on testing by Aidan Fowler (Deputy Chief Medical Officer for England) included the following information, "*[testing] capacity will be used for surveillance, and possibly symptomatic community testing, track and trace, and asymptomatic testing of all NHS and social care*

staff. But opening up testing too much may overwhelm capacity" [INQ000068951_0003]. A report authored by Mr Johnstone summarising the international and UK evidence on outbreak management in care homes, titled, 'COVID-19 in care home settings: Enhanced Prevention and Outbreak Management' [INQ000089662] was also considered at this meeting. This paper refers to the CDC [INQ000224063] and PHE Easter 6 studies [INQ000320602], and also a study from Singapore by Tan *et al.* The paper reaches similar conclusions to the GO-Science paper of 14 April 2020, and states "*there is asymptomatic transmission of COVID-19 in care homes among both residents and staff*", and "*by the time a single symptomatic case is identified in a home, the virus will already be circulating in the home amongst residents and staff*" [INQ000089662_0003]. The paper lists actions that are likely to be effective as advised by the UK Centre for Evidence Based Medicine from a review of international evidence, including, "*Testing of care homes residents and staff supports the home to rapidly respond and put additional measures in place to contain and prevent further spread*" [INQ000089662_0002]. The paper also states, "*Among countries that appear to have had success in preventing COVID-19 entering into care homes, such as Singapore and South Korea, there have been very strict processes to isolate and test all care home residents and staff who not only have symptoms, but who may have had contact with people who have COVID-19*" [INQ000089662_0003].

32. On 24 April 2020 Dr Chris Jones sent two emails to WG, PHW and CIW colleagues, captured within the email chain [INQ000336445]. The first timed at 10:29 states, "*This is the English care home paper, discussed with the UK Care Minister yesterday and senior clinicians last night*" [INQ000336445_0002] (believed by CBFJC to be Mr Johnstone's paper referred to in §31 above). The second is addressed to PHW colleagues, Andrew Jones and Julie Bishop, and states, "*I know you are currently working on revising the PHW guidance for residential settings in light of discussions over the last week and are also considering the attached PHE update document shared this morning. Albert Heaney is very keen that this is done urgently and guidance issued...Albert has also said he wants: "Global testing of residents; Staff testing addressed; Dom support work testing"*" [INQ000336445_0002]. This email prompts a response from CIW that "*...all staff (and residents in care homes) should be tested whether they are asymptomatic or not and in truth these tests need to be repeated at regular intervals*" [INQ000198311].
33. On 24 April 2020 PHW produced updated draft guidance to prevent Covid-19 in residential care settings [INQ000395608]. Inexplicably, this guidance does not require a negative test upon discharge, and it advises that positive symptomatic patients can be discharged to a care home subject to isolation [INQ000395608_0004]. Further, the guidance allows for the testing of symptomatic residents only, and states, "*Where capacity allows further testing of residents will be undertaken*" [INQ000395608_0008]. At §227 of his witness statement, Professor Khaw describes the reasons for this approach

as, “the guidance was drafted to reflect this pragmatic approach while the system scaled up capacity...PHW’s concern was...without any clear indication of prioritisation in situations where capacity had not yet been scaled up, would have put people at greater risk” [INQ000587702_0064]. At §230, Professor Khaw further explains the difficulties encountered as, “Welsh Government Officials were requesting changes to Public Health Wales guidance, which were not wholly consistent with the formal Welsh Government policy communications at the time” [INQ000587702_0065].

34. On 25 April 2020 Professor Sir Chris Whitty emailed colleagues “I was v struck by this paper from NEJM yesterday. It’s from the US and not strictly comparable, but I think gives some feel for the burden of asymptomatic carriage” [INQ000229085_0001]. The paper referred to was published on 24 April 2020¹, and concludes that, “More than half of residents with positive test results were asymptomatic at the time of testing and most likely contributed to transmission”.
35. On 26 April 2020 guidance was provided by DHSC Social Care Testing Cell [INQ000478887], which includes the following information, “The continuing growth in testing capacity has opened up new opportunities for testing targeted at particular priorities, including - in particular circumstances - testing of individuals not exhibiting symptoms. This has been enabled by a change in Public Health England guidance (approved by the Chief Medical Officer) this week, confirming that there is no barrier to testing asymptomatic people where clinically appropriate...Used in the correct circumstances, testing of asymptomatic individuals can have a number of benefits, including: - Developing understanding of prevalence and incidence of infection and how both change over time. - Exploring key vectors of transmission and effectiveness of public health interventions. - Supporting infection control, providing an ability to proactively identify those who are yet to develop COVID symptoms” [INQ000478887_0001-2].
36. On 28 April 2020 Alison Machon emailed PHW [INQ000520936_0001] and expressed dissatisfaction with the draft PHW guidance of 24 April 2020 [INQ000395608], stating that it “is not consistent with the 2 letters issued by the Deputy Director General [Albert Heaney] and CMO [Sir Frank Atherton] last week, the paper on care homes from PHE last week which identified two sources of infection as staff and hospital discharge...**It also doesn’t pick up on the areas Albert has asked to be addressed in terms of global testing of care home residents and staff testing including to identify risk from asymptomatic staff** [emphasis added]”.
37. In a separate email of 28 April 2020 [INQ000396501], Ms Machon communicated the above dissatisfaction to Mr Heaney and Sir Frank Atherton, to which Sir Frank replied, “/

¹ Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility, New England Journal of Medicine: <https://www.nejm.org/doi/full/10.1056/NEJMoa2008457>.

*thought we had agreed to test all hospital discharges and all **symptomatic** residents and staff but not asymptomatics*” [INQ000396501_0002]. Within this chain, once again, CIW advocate strongly in favour of regular asymptomatic testing, stating, *“the idea of asymptomatic staff and residents spreading the virus would be an unacceptable risk”* [INQ000396501_0002].

38. On 28 April 2020 PHE circulated an options paper by email [INQ000396502_0003] to PHW that advised of DHSC’s intention to roll out *“regular **screening testing** of ALL residents and staff in care homes, regardless of whether they have symptoms or signs suggesting COVID-19 infection”*. PHE’s email and options paper was subsequently forwarded the same day to WG colleagues, including Sir Frank Atherton, Dr Gillian Richardson, Dr Chris Jones and Albert Heaney [INQ000396502_0001-2]. The options paper [INQ000500175] includes the following statements, *“...the care sector is seeing a large number of cases and outbreaks. One-third of care homes (4,300 in total) have now reported cases or outbreaks of COVID-19; these outbreaks have been associated with mortality of up to 40%”* [INQ000500175_0001] and, *“There are significant organisational issues where a high proportion of staff screened test positive, and asking them to remain off will likely mandate reliance of agency staff...”* [INQ000500175_0002]. On the same day (28 April) at a meeting between UK Health Ministers, Matt Hancock, Vaughan Gething, Jeane Freeman and Robin Swann, Mr Hancock provided an update on testing, including the asymptomatic testing of people in care homes [INQ000279763_0002]. As is apparent, there was extensive sharing between UK governments of information on testing policy both at Ministerial and Senior Clinician level, and suggestions by the WG to the contrary are simply an extension of their strategy at the Inquiry to obfuscate and to blame others.
39. On 29 April 2020, Mr Drakeford told the Senedd when asked about routine testing in care homes, that *“the clinical evidence tells us that there is **no value** [emphasis added] in doing so”*. CBFJC consider it likely that Mr Drakeford’s inspiration for this choice of words is an email of Tracey Cooper of PHW from a month earlier, on 29 March 2020, when responding to an email from a Welsh Assembly member, Darren Millar [INQ000336344]. Mr Millar had asked when routine testing of new residents would begin given the vulnerability of care home residents, to which Ms Cooper provided advice (known to be incorrect even then) that, *“If new residents (or existing residents) do not have any symptoms prior to admission, there is no value in testing for the presence of the coronavirus”*. This response was brought to the attention of Dr Andrew Goodhall (Director General Health and Social Services) on 30 April 2020, who commented, *“given broader questions about care homes and testing this is a helpful reference point for current testing regime”* and brought it to the attention of Mr Gething to be similarly deployed.
40. A notebook entry of Jane Runeckles (SPAD) [INQ000327608_0032-0033] records a meeting between Mark Drakeford, Vaughan Gething, Sir Frank Atherton, Dr Rob Orford,

and Dr Chris Jones on 30 April 2020. The entry records that Sir Frank Atherton and Dr Orford indicated that the approach is to test all that are symptomatic, and that it is not possible to test all 25,000 people in care homes every four days. Dr Orford indicated that some people are infectious before they are symptomatic, and begged the question, "*is there an argument for testing asymptomatic*". Dr Jones suggested that further testing will not tell them any more, and that the approach should be to assume everybody is positive and treat them accordingly. Mr Drakeford remarked, "*what difference does it make to how you are running the care home. Testing gives you information but not a solution*". The CBFJC make two observations about this meeting. First, it is clear that the reason for not proceeding with asymptomatic testing in care homes is because of a lack of capacity (25,000 people every 4 days) and not based on scientific and medical advice (as WG continues to suggest). Second, given the wealth of information within the knowledge of WG at this date about the need for asymptomatic testing to control infections in care homes, the level of ignorance demonstrated by these most senior decision makers in WG, typified by the statement of Mr Drakeford, "*what difference does it make...*", is astonishing.

41. On the same date, Albert Heaney (who is not indicated to have been present at the meeting on 30 April 2020) caused an email to be sent to NHS Wales colleagues that states, "*Albert Heaney has asked that we provide you an update on Care Home Testing policy for committee today. See attached a draft position paper setting out current status. Claire Rowlands is developing a fuller paper for the FM by this evening, on testing which will include options for expanding testing for asymptomatic individuals as announced by UK Government earlier this week*" [INQ000501509].
42. Also on 30 April 2020, Claire Rowlands, who since 18 April 2020 had been working on a Ministerial Advice on testing policy, following the advice of PHW from 18 April 2020, sent an email to Sir Frank Atherton [INQ000367481]. This email sought Sir Frank's approval for recommendations in the draft Ministerial Advice, including the following statement, "*Discussions with colleagues in Welsh Government and PHW indicate that testing of asymptomatic (or reportedly so) care workers would help to prevent introductions into care homes, and also provide an estimate of community incidence of COVID, and so targeting testing in the following ways (and this is being explored for health care workers):*
a. Serial testing of care home workers in care homes free of Covid-19. That would involve testing all care home workers in around 700 homes as it currently stands. This would need to be modelled and take time to get up and running..." [INQ000367481_0001]. Approximately 30 minutes later Ms Rowlands emailed Sir Frank Atherton again, and stated, "*Just seen your other email Frank, so will remove the serial testing bit...*" [INQ000367483]. CBFJC have not been able to locate Sir Frank's reply to email INQ000367481. However, it seems clear that the CMO requested that the scientific advice, that asymptomatic testing of care workers would help to prevent the introduction

of infection into care homes, be removed from the Ministerial Advice. Again, CBFJC have two observations. First, Sir Frank Atherton was in receipt of a wealth of information from the UK Government, PHE, PHW, and his extensive engagement with UK counterparts to know that asymptomatic testing would help reduce infection in care homes. Second, it is reasonable to infer that it had already been decided in advance not to proceed with asymptomatic testing, and the direction to remove reference to the scientific advice in favour of asymptomatic testing was for the purposes of enabling that predetermined outcome.

43. The Ministerial Advice dated 30 April 2020 that was formally submitted for decision [INQ000336477] includes the following statements: “*We also intend to increase testing within care homes as more testing capacity becomes available*” [INQ000336477_0002]; “*There is some evidence to suggest that there are asymptomatic residents who are undetected and be a source of infection: A pilot study recently undertaken by PHE in six care homes in London...results from one care home...75% of residents were positive for COVID-19 but only 25% were symptomatic. 50% of staff were positive but only 29% of these were symptomatic; and a study by the [CDC]...Twenty-three (30%) residents tested positive, of these, 10 (43%) had symptoms on the date of the test and the remaining 13 (57%) were asymptomatic. Seven days after testing, 10 out of 13 of the asymptomatic residents had developed symptoms. This study suggests that symptom-based screening in long-term care facilities could fail to identify approximately half of residents with COVID-19*” [INQ000336477_0004]; “*Modelling suggests that we would need to [sic] 25000 extra test per week for care homes to be able to test all residents - that doesn’t include care home workers*” [INQ000336477_0004]; “*New evidence from England supports a targeted testing at care homes with outbreaks and larger care homes...Expanding into asymptomatic individuals still lacks the evidence base to support this being the best use of testing capacity*” [INQ000336477_0005-6]. The information within this advice, in particular the findings of the PHE study, makes plain the urgent need to test within care homes asymptotically and that the reason this cannot be implemented is because of a lack of testing capacity. The suggestion of a lack of ‘evidence base’ is absurd and is inserted to provide cover for the fact that essential safety measures could not be implemented because of a lack of testing capacity.
44. The WG knew that the case in favour of asymptomatic testing was even stronger than that set out within the final Ministerial Advice, and this does not simply relate to the deletions instructed by the CMO on 30 April. Until at least 29 April 2020 (the day before the advice was finalised) the draft Ministerial Advice contained the following accurate reflection of the scientific position: “*our current policy in Wales is to test all symptomatic residents and staff...Evidence suggests that this approach results in asymptomatic Covid-19 individuals, many of whom will go on to develop symptoms, not being identified and a source of ongoing risk to residents and staff...International evidence suggests that*

- increasing testing in care homes for asymptomatic staff will provide added protection against the virus in the sector* [INQ000367477_0007, and 0009]. CBFJC has not been able to determine on whose direction this accurate statement of the science was removed from the Ministerial Advice. It is possible that it was again the CMO, but whoever, CBFJC can only surmise that it was removed to aid the impression that the decision of the WG had some sort of scientific and medical legitimacy, whereas the reality was WG knew full well that they ought to be testing asymptotically but simply did not have the capacity.
45. In contrast to the approach taken by WG, a WhatsApp exchange [INQ000102062] between Professor Whitty, Sir Patrick Vallance, Matt Hancock, Boris Johnson and Dominic Cummings on 3 May 2020 demonstrates their collective knowledge of the importance of testing in hospitals and care homes at this date, and includes the following statements: *“I don’t understand why we are still not testing more NHS staff and care home staff including asymptomatic...we know the most vulnerable are in hospitals and care homes”* (Cummings); *“We should be and we have said that”* (Vallance); *“We have been doing this for the past week”* (Hancock); *“On testing in care homes and hospitals everyone agrees now we have the capacity we should be doing a lot more. It’s not a panacea but it would definitely help”* (Whitty) [INQ000102062_0001-2].
46. Whereas in Wales, undeterred by the clear evidence within the Ministerial Advice of 30 April 2020 of the risk to life of asymptomatic transmission within care homes and the need for asymptomatic testing in response, Mr Drakeford doubled down on the false claims made a week earlier, and on 6 May 2020 told the Senedd that he had not seen *“any evidence”* that asymptomatic testing had any *“clinical value”* in homes where there was no coronavirus in circulation.
47. These views are of course absurd, and they were known to be so at the time. Peter Halligan, Chief Scientific Adviser for Wales, caused an email to be sent to Dr Rob Orford and Fliss Bennee on 30 April 2020 upon hearing them on the first occasion, which reads, *“Dear Rob, Fliss, Peter Halligan is keen to understand the rationale, evidence and advice behind the First Minister’s comments last night on the telly that there is no value to testing for Cov-19 in care homes. Please can you enlighten us.”* [PHT000000073_0046].
48. Further, the statement made in the Senedd on 6 May 2020 by Mr Drakeford was directly contrary to the following statements that asymptomatic testing did have clinical value, made within the Ministerial Advice of 30 April 2020, as follows: *“Discussions with colleagues in Welsh Government and PHW indicate that testing of asymptomatic (or reportedly so) care workers **would help prevent introductions into care homes** [emphasis added], and also provide an estimate of community incidence of COVID”* [INQ000336477_0005]; and *“If more on prevention side, testing which shows asymptomatic carriage, **could potentially prevent outbreaks** [emphasis added] by screening all homes”* [INQ000336477_0010]. In these circumstances, the statements

made by Mark Drakeford raise a serious question about whether the Senedd was deliberately misled.

49. Mr Drakeford was not alone in making such false statements. During a question-and-answer session on 23 June 2020 (reported at INQ000587938, and also publicly available on video²) Mr Gething was asked the question, “*The Welsh Government has said that the scientific advice was it would not be a good use of testing capacity to test asymptomatic patients until the end of April. If it was the case that there was a lack of testing capacity that caused this advice, was it the fact that there wasn’t enough tests that meant you made the decision to not test people who were going into care homes until the end of April?*” To which Mr Gething responded, “*No...we based our decisions on advice and evidence*”. The journalist continued, “*Surely if you’d had enough tests to have been able to test everyone, you should have been testing everybody who went from a hospital into a care home. And it was the fact that you didn’t have enough tests that made that advice the advice that it was at the time*”. Which elicited a similar response from Mr Gething, “*No...you’re just wrong...if we had treble the amount of testing capacity...then that was still the evidence and advice that we had...we didn’t get advice that said, ‘you really should do this but you can’t because you don’t have testing capacity’*”. CBFJC suggest that the evidence above establishes that a lack of capacity was precisely the reason that asymptomatic testing was not introduced sooner in Wales, and that the public statements made by Mr Gething in his capacity as Minister for Health and Social Services on 23 June, were not accurate.
50. Against this background of dithering, false statements and U-turns, it was difficult for bereaved families in Wales to hear the explanation offered by Mr Drakeford, in his recent oral evidence in Module 7 that, “*we planned first and then we announced. And sometimes that makes us look like we were doing things later than was happening elsewhere, but I believe that our method was more effective*”. What was more effective, the group asks, about repeated delays in the implementation of essential safety measures which endangered the lives of so many of the most vulnerable people in Wales? Further, WG was not planning how to implement routine testing in care homes before their introduction on 16 May; it was denying that there was any clinical value.
51. Even once asymptomatic testing within care homes was finally introduced on 16 May 2020 the guidance issued was confused and contradictory. The statement of Vaughan Gething of 16 May 2020 [INQ000182446] stated that testing will be offered to all symptomatic staff and residents who have never tested positive before, with “*testing to be rolled out to all care homes in a matter of weeks*” [INQ000182446_0002], i.e. not

² Available online at: https://www.pscp.tv/w/ezWTDDFQWEtkcVIYUE12amV8MUJkR1lucGxlUXpKWLE3rNHhg9n66M2-KewIRuVYm1X1irTs17IPwFADyn2?t=fRzf-wyHbUrKP8mCtK_gLQ&s=03

immediately. Thereafter, Sir Frank Atherton and Albert Heaney issued a letter to care home providers on 20 May 2020 [INQ000500188] to inform that rapid testing would be undertaken in care homes registered for 50 or more beds within the next two weeks, and that the testing of staff and residents in smaller care homes who do not have a Covid-19 infection will be delivered either by the relevant health board or through the new social care portal, "*which goes live shortly*" [INQ000500188_0002]. The target date for completing testing was 14 June 2020 [INQ000221150] which indicates that this was a one-off rather than repeat testing of residents. On 9 June, Vaughan Gething announced that care home staff would be offered a weekly test for a four-week period from 15 June 2020 [INQ000198394], which was extended in July [INQ000227202], and scaled back to fortnightly from 6 August 2020 with a review in October 2020 [INQ000368201].

52. What this amounts to is one-off asymptomatic testing of residents in care homes between the end of May and 14 June 2020, and thereafter routine testing of care home staff from 15 June 2020, all of which occurred after the first wave and too late to make any meaningful impact. A pathetic response from an incompetent government that failed to communicate the truth of what was happening to the people of Wales.
53. Further evidence that the clinical value of asymptomatic testing was well understood within WG and PHW can be found within the witness statement of Professor Khaw [INQ000587702, §218] in which reference is made to a Journal of Public Health article of 15 May 2021 [INQ000520960]. Although this article was not published until 2021, the findings were based on data collected from care homes in Wales between February and May 2020, and of the six authors, five are PHW scientists. The article finds, "*The delayed and lack of testing early in the outbreaks and delays in isolating residents before they became symptomatic are both likely contributing factors to the extensive transmission of COVID-19 in these homes*" [INQ000520960_0006], and "*Care homes should be enabled to take proactive steps to prevent introduction and transmission of COVID-19, including restricting visitors, universal testing, and isolation of residents as required. Waiting for identification of the first case before taking action does not appear to be a sufficient strategy for preventing an outbreak*" [INQ000520960_0006].
54. This, coupled with the need for adequate IPC, including PPE, RPE, and ventilation, is the key lesson of the awful experience of the pandemic for reducing transmission among elderly vulnerable people in care homes. CBFJC submit that it is clear from the evidence set out above that WG and PHW knew from early to mid-April 2020 of the need for widespread asymptomatic testing in these settings, and that reason it was not implemented was not because the science did not support such action until 12 May 2020, as WG claims, but simply because of insufficient testing capacity. What so incenses the members of CBFJC is that the continued false claims of WG that the policy was based on science and not a lack of capacity is for the purpose of evading responsibility, and in

doing so not only does it demonstrate a lack of integrity and accountability, it risks failing to learn from past mistakes. If the truth is acknowledged, it will be clear that better preparation could have avoided the severity of the impacts of the pandemic, but unless this is done, we are destined to repeat the same mistakes. The tragedy of the approach of WG is that it puts the reputations of a small number of Welsh politicians above the wider public interest.

Second - inadequate IPC and PPE

55. The numerous delays and failures in testing care home workers and residents meant that infection prevention and control (IPC) became even more vital to prevent the spread of Covid-19 within care homes in Wales. However, the reality was that many Welsh care homes were small, and their physical infrastructure created problems implementing IPC measures, effectively isolating residents and ensuring proper ventilation.
56. The Inquiry heard that WG's practice of discharging patients from hospitals into care homes without testing was taking place "*at a time when [PHW was] really clear that isolation provided an additional control measure, so that in the case of any positive or infectious individuals, we were able to also, through that measure, control transmission in that setting*" [Day 6/130:20]. However, this approach failed to take into account that isolation was not always possible in many homes, in particular where residents had dementia. In response to a question from the Chair, Professor Khaw acknowledged the "*real-life situation*" and difficulties for care homes: "*Technically, theoretically, isolation is a good control measure. But practically speaking, in care homes, particularly smaller care homes with highly vulnerable populations, it is difficult. I accept that*" [Day 6/131:15].
57. PHW purported to be "*familiar with the care sector's constraints in some of the care home environments*", and capable of providing "*practical advice on how [a care home] might... maintain infection prevention and control*" [Day 6/113:15]; however, CBFJC question the quality and feasibility of the advice provided to care homes when control measures such as isolation were - practically, rather than theoretically - very difficult to implement.
58. Another control measure, ventilation, was a huge challenge for many care homes and there was a marked lack of support and guidance from WG to help care homes improve their ventilation and air quality. Reflecting on the pandemic response, the CMOs and DCMOs highlighted in the UK-wide technical report that air quality in care homes is not currently well understood, but that it is key to mitigating the impacts of acute respiratory infections in future pandemics [INQ000101642_0303].
59. Professor Rayner, on behalf of the National Care Forum, told the Inquiry of the report commissioned from Eric Fewster, an Independent Water and Environmental Manager, who advised in April 2020 that natural ventilation (opening doors and windows) may not provide the ventilation rate required to significantly reduce airborne transmission risk even in summer, and with windows closed (i.e., during winter months), the only reliable

- way of reducing the risk of airborne transmission was to install a mechanical system, such as a ventilation system and/or a recirculating HEPA air filtration system [Day 4/112:14].
60. However, Helen Hough told the Inquiry that her care home did not have a ventilation system, which became more of a problem coming into the second wave: *“By winter, we knew that ventilation was crucial, but we could not keep doors and windows wide open”* [INQ000587639_0015, §69]. Nor did her care home have any HEPA filters and *“[i]n fact, there was never any discussion around HEPA filters within the care home sector – whether before the pandemic or in early 2020...the sector was not at all prepared for an airborne pandemic”* [INQ000587639_0015, §69].
61. The value of HEPA air filtration was recognised in a Summary Brief by the Welsh Technical Advisory Cell (the body that coordinates scientific and technical advice to support WG decisions makers) in July 2020, which stated: *“Control Measures for Airborne Infection: SAGE EMG has already considered that the virus could be transmitted through airborne routes and has included this in relevant papers on transmission and recommendations for mitigating risk...**Good ventilation is well recognised as a primary measure for controlling the risk of airborne disease transmission.** A well ventilated space reduces the concentration of viral load in the air and hence the probability of infection...Evidence to date suggests that poorly ventilated spaces pose the highest risk, so it is recommended that mitigation measures focus on those spaces where ventilation is absent or inadequate...The use of recirculating air cleaners may be appropriate in small spaces where ventilation is poor and cannot be easily improved. **Devices which use HEPA or UV-C are likely to be the most effective**...Ensuring good ventilation of buildings is a particular concern for winter, where cold/adverse weather means that ventilation rates are often reduced to manage thermal comfort [emphasis added]”* [INQ000311892_0047-49].
62. Professor Beggs in his evidence in Module 3 highlighted the study by Conway Morris et al, from 22 September 2021, which showed that the use of supplementary HEPA filter air cleaning devices on a hospital ward was associated with greatly reduced SARS-CoV-2 RNA levels in the air [INQ000474276_0057], and in his recommendations, Professor Beggs commented that *“The evidence base in support of portable HEPA devices, in particular, is reasonably strong, since these perform a similar task to mechanical ventilation systems, and as such are a mature well-established technology that is quick and relatively inexpensive to deploy”* [INQ000474276_0013].
63. Despite the clear recognition that Covid transmitted via the airborne route, and that HEPA air filters were a cheap and effective mitigation, there was no support for or recommendations to care homes in Wales to utilise HEPA air filtration coming into the second wave.
64. Other aspects of infection prevention and control were impossible to implement within a

care setting. For example, the guidance that staff distance themselves by two metres from residents was totally unrealistic. Helen Hough said in her evidence: *“It’s impossible. To begin with, you can’t move anybody on your own. You can’t nurse a patient without touching them. But also, you need two carers”* [Day 2/111:10].

65. And a modelling study into SARS-CoV-2 outbreaks in English care homes noted the limitations of its work because it did not consider the effect of staff absence on rates of transmission, which were likely to increase due to remaining staff being overstretched and therefore more likely to carry out sub-standard IPC.³
66. Because social distancing and other IPC measures were often impractical or difficult to implement in care home settings, what was needed to minimise transmission of infection to vulnerable residents was the right type and the right quantity of PPE/RPE for care home workers. However, this was a further area where WG inadequately protected care home staff and residents.
67. Despite recognition by WG of the need to provide PPE to care homes as early as 18 February 2020 [INQ000470674], it was not until 19 March 2020 that the remit of NHS Wales Shared Services Partnership (NWSSP) was extended to procure and supply care homes, distributed by local authorities. Those operating at a local authority level, however, felt that WG failed to recognise the needs of social care settings, as it prioritised supply of PPE for the NHS [INQ000518355_0009, §§19 and 21].
68. Guidance was issued to social care providers in a letter from Vaughan Gething on 18 March 2020, which directed that PPE should be worn by staff providing direct care to patients suspected or confirmed as having Covid-19. However, despite this guidance, some care homes in Wales received no PPE until the end of April or early May, and by 7 May 2020, only two-thirds of Welsh care homes had their PPE requirements met by the NWSSP [INQ000587254_0028, §112] – too late to prevent widespread infection and deaths.
69. A study into the introduction and spread of Covid in care homes in Norfolk⁴ found that once introduced into the home, the subsequent spread of suspected Covid-19 was largely associated with inadequate access to PPE, most especially facemasks (which is likely to be similar to position facing care homes in Wales). There is ample evidence before the Inquiry that Welsh care homes did not have sufficient quantities of PPE: Helena Herklots (Older People’s Commissioner for Wales) told the Inquiry there were inconsistent supplies to care homes [Module 2B, Day 2/124:5]; Chris Llewelyn (Welsh Local Government Association (WLGA)) said local authorities were unable to obtain supply of requested items through NWSSP at points throughout the pandemic, and *“demand for*

³ Rosello et al. (01 April 2022) - Impact of non-pharmaceutical interventions on SARS-CoV-2 outbreaks in English care homes: a modelling study: <https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-022-07268-8>

⁴ Brainard et al. (28 December 2020) - Introduction to and spread of COVID-19-like illness in care homes in Norfolk, UK: <https://pmc.ncbi.nlm.nih.gov/articles/PMC7798982/>

PPE was met 'on paper' however in practice the supplies could not be utilised by care professionals" [INQ000518355_0020, §§46-47]; Mr Llewelyn also referred to WLGA survey results that showed a third of local authorities said it was very difficult for care providers to access PPE, with common problems being erratic deliveries and the quality of PPE, and that *"six local authorities said orders of PPE being diverted to the NHS happened very often or fairly often"* [INQ000613908_0065, §175]; CFW wrote to the First Minister for Wales, Mark Drakeford, on 8 April 2020 on behalf of members who run care homes for the elderly stating *"our members feel they are barely receiving sufficient PPE to care appropriate for existing residents"* [INQ000499629_0002].

70. Moreover, the PPE packs prepared and distributed by NWSSP failed to provide the right type of PPE, because of a failure to recognise from the outset of the pandemic (as should have been done in accordance with a precautionary approach) that Covid-19 is transmitted via aerosols. Instead, advice from PHW to WG on 24 March 2020 stated, *"Based on the current available evidence, the COVID-19 virus is transmitted between people through close contact and droplets, not by airborne transmission. The PPE required for contact and droplet precautions in the UK is Gloves, Aprons, Fluid Repellent Surgical Mask (FRSM) and eye protection (risk assessed depending on risk of splash) - FFP3 masks are only required for aerosol generating procedures (AGPs)"* [INQ000252515_0003].
71. The failure to recognise Covid as an airborne respiratory infection, which could be transmitted asymptotically, had a significant and detrimental impact on the PPE that was advised for health and social care workers providing care to patients with Covid-19. On 16 March 2020 Vaughan Gething advised that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. And within a letter to social care providers on 18 March 2020, following Mr Gething's announcement, it was confirmed that (i) PPE was for those directly caring for confirmed or suspected cases, and (ii) a higher level of PPE was *"unlikely to be needed"* in a social care setting, such equipment only being needed by those undertaking AGPs [INQ000470681].
72. However, FRSM or surgical masks are ineffective protection against an airborne respiratory infection, and FFP3 respiratory protective equipment was needed. Helen Hough was clear on this issue in her statement: *"We were not provided with FFP3 respirators, but I bought them (at great cost) on Amazon. If we thought a patient had Covid-19 (for example, because they had a temperature), we wore an FFP3 respirator instead of a surgical mask. As nurses, we knew a surgical mask would not protect us. They do not fit your face, there are gaps at the side, and they are designed to stop the wearer coughing or passing infection to a patient. They do not prevent a healthcare worker from catching infection from a patient by inhaling infectious aerosols, which is why I was asking for FFP3. I knew nurses in intensive care and critical care wards were*

receiving FFP3...” [INQ000587639_0016, §78].

73. Helen Whately also raised this concern in her oral evidence, when referencing the lower rates of infection among ICU staff who had the benefit of FFP3 respirators, and she described the inadequacy of PPE and RPE in social care settings as not “*good enough in the light of the way Covid spread*” [Day 12/80:7].
74. The need for adequate protection in care homes was raised in an email to Vaughan Gething by a Welsh Government Special Adviser on 7 April 2020, who highlighted that residential and domiciliary care staff “*clean, bathe, dress, feed, change dressings and all manner of close up activity, and the idea that district nurses will enter the same premises fully equipped (as is often observed) and they do not, continues to simply jar*” [INQ000349300_0001]. Yet no action was taken by WG. The failure to recognise that airborne transmission was a significant route of transmission, to recommend the use of RPE, and to provide this protection to care homes, undoubtedly contributed to higher levels of nosocomial infection and deaths within care home settings.
75. These inadequate PPE measures in the IPC guidance remained in place throughout the pandemic. This meant that the lack of appropriate respiratory protection, coupled with the absence of effective testing regimes, and the very nature of adult residential care - which does not allow for social distancing and requires close personal care - created a perfect storm for the virus to transmit rapidly among extremely vulnerable people. This was known from the outset by those on the frontline, like Ms Hough, but ignored by decision makers.
76. Alarming the most recent PHW IPC guidance for Acute Respiratory Infections in Wales (2024-25)⁵ continues to recommend that social care staff use “*FRSM (type IIR) when working in respiratory care pathways and when clinically caring for suspected/confirmed COVID-19 and Flu patients*” [p.8] and only recommends FFP3 masks “*if an unacceptable risk of transmission remains following the hierarchy of controls*” [p.15]. Given the lack of adequate ventilation and isolation facilities in the majority of care homes in Wales, and the need for the provision of close personal care, the ability to apply a hierarchy of controls in these settings is extremely limited, and in these circumstances the continued recommendation of surgical masks shows how little has been learned from the tragic events of the pandemic, and makes the failures to provide appropriate PPE and RPE all the more indefensible.

Third - care home residents were deprioritised

77. Social care across the UK was described by many as a ‘Cinderella’ service, including by Alwyn Jones (ADSS Cymru) who said “*consideration of social care in the context of a number of decisions was always later than the NHS...it felt like the initial narrative was*

⁵ <https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/infection-prevention-control/ari-a-z/infection-prevention-and-control-measures-for-acute-respiratory-infections-ari-for-health-and-social-care-settings-wales-2024-version-30/>

around the challenge within the NHS” [Day 15/114:3]. The focus in Wales on protecting hospitals and discharging patients to free up hospital beds resulted in a lack of consideration by NHS staff of the safety and wellbeing of elderly residents of care homes and social care staff [INQ000528094_0033, §4.44].

78. Vaughan Gething, when asked about the widely held view that adult social care is the ‘Cinderella’ service, responded that, *“I recognise where that comes from because it’s relatively low paid but actually it’s hugely important...And I think the public don’t really appreciate the residential social care sector and the domiciliary care sector, because it is not as visible as the health service”* [Day 10/5:3]. However, this response totally ignored his responsibility as Minister for Health and Social Care to ensure that the decisions taken in the pandemic response, and the public statements made, reflected the importance of the social care sector and those living and working in care homes. The reality is that public briefings and policy announcements consistently focused on NHS capacity and resilience and rarely were care homes mentioned with any urgency or specificity. This absence from the public narrative mirrored their exclusion from WG decision-making. In a letter from CFW to the First Minister on 8 April 2020, they wrote: *“our members [who run care homes for the elderly] across Wales do not currently see the clarity of thinking and delivery of resources to match the stated national focus on protecting the vulnerable, when those vulnerable people are care home residents. At present, CFW is unable to reassure its members, as we have no evidence that Welsh Government - through its agencies - will provide significant resources that would be needed if care homes have (as they will if the virus enters) significant number of residents with the infection”* [INQ000499629_002].
79. Professor Banerjee in his evidence said that, *“If your internal compass faces away from people who are old, then you may be more likely to decide that individuals don’t get a test, are sent back to their care homes, or sent back home, rather than afforded the extra care that can be provided in a general hospital”* [Day 15/21:21]. CBFJC submit that this tendency was displayed very clearly by WG and public bodies in Wales, which consistently disregarded the safety and individual care needs of care home residents.
80. This pattern of neglect was not incidental - it was systemic. WG’s prioritisation of NHS capacity over the wellbeing of care home residents was evident early in its pandemic strategy. The decision to discharge patients from hospitals into care homes without mandatory testing or sufficient RPE, despite known risks of asymptomatic transmission and the increased vulnerability of care home residents, put those residents at direct risk of infection and death. There was a hierarchy of concern in which hospital capacity was valued more highly than minimising transmission of infection in residential care settings. As CFW put it, in a letter to Mark Drakeford on 8 April 2020, *“the current discharge approach - without tests and without sufficient full PPE - gives the appearance of ‘sacrificing’ the 20,000 older people in care homes in Wales, quite apart from putting staff*

at risk" [INQ000499629_0002].

81. Testing eligibility and regimes early in the pandemic further illustrate this deprioritisation. The Inquiry heard there was a "*clear prioritisation matrix*" [Day 6/121:24], which included symptomatic residents in care homes but not asymptomatic care home residents or staff. The delay in rolling out routine testing in care homes meant that outbreaks were not detected early, it became more difficult to prevent transmission and those most vulnerable to infection were placed at unnecessary risk.
82. The Equality and Human Rights Commission, which investigated WG decision making around care home residents following a referral by the Older People's Commissioner for Wales, found that "*a number of decisions in the Covid-19 response may have resulted in failures to adequately protect the right to life, including decisions about hospital discharges, admissions to care homes, prioritisation of testing and access to necessary healthcare and treatment*". Their report states that, "*Representative groups have described how the combination of decisions in the pandemic response either ignored care home residents or treated them as expendable*" [INQ000253853_0012, §32].
83. In a similar vein, there is evidence that care home residents in Wales could not always access hospitals when they needed them. Ambulance teams were reluctant to transfer residents to hospital, and almost half of Local Authorities in Wales reported that necessary transfers of residents to hospital were not undertaken. The witness statement of Helen Hough details an ambulance team refusing to take a resident to hospital because they had a temperature, and the ambulance team's instructions that they were not supposed to transport anyone from a care home [INQ000587639_0006-7]. Ms Hough recounted the conversation with the ambulance crew in her oral evidence, "*they said to me, "The hospital aren't going to be very pleased with this", and I went outside the building and I did say to the ambulancemen, "It's not up to you to play God here. You're just taking in poorly patients into hospital. You don't get to decide...who lives or dies in this home"*" [Day 2/131:5-10].
84. The blanket application of DNACPR forms on the medical records of care home residents - without discussion with them or their families - was a particularly egregious example of systemic disregard. DNACPR was used as a proxy for 'Do Not Treat', resulting in automatic non-admittance to hospitals and patients not receiving the care and treatment they needed, which may have prevented death. One Welsh care home manager gave the following harrowing account of the circumstances of the death of a resident who did not receive adequate treatment and care: "*For whatever reason, perhaps because they weren't confirmed as Covid-19, or perhaps because sufferers can take a turn for the worst and death can come on quite quickly, no palliative care package was put in place by the GP and controlled drugs were not issued to try to ease them with any possible suffering...[The patient] unfortunately passed away within 24 hours and the manner of their passing has affected some of the staff quite badly with [the patient] struggling to*

breathe and in effect slowly suffocating to death. Nobody should have to die like this. I get the fact that these are extraordinary times and we are in the middle of a crisis, the like of which none of us have seen before. However, there appears to be [a] race by GP's to place DNACPR on lots of individuals, which would mean automatic non-admittance to hospitals and possibly many more examples of these horrific deaths, and with no apparent thought as to how if people suddenly take a turn for the worst how they may be helped to pass in a more comfortable and humane way...Care homes do not have a general supply of stock medication supplies for end of life care, nor access to oxygen. How confident are we that residents and their families understand the implications of a DNACPR?" [INQ000500163].

85. In particular, the lack of oxygen, palliative care and medication to ease the suffering of those dying from Covid-19 in care homes was cruel and inexcusable. CIW raised concerns directly with WG from March and April 2020 about the need to support care homes providing end-of-life care to patients with Covid-19: *"family members will be distraught if they are aware of these details. In these extraordinary conditions it is imperative that people who die in care homes with Covid 19 are treated with dignity, compassion and can be made as comfortable as possible"* [INQ000500163].
86. The directive for GPs to shift to remote consultations where possible in order to reduce the risk of infection meant that interactions between GPs and care home residents were often conducted virtually. Combined with the suspension of non-Covid healthcare services for long periods of time, this shift meant that for many residents, regular check-ups, diagnostics and timely medical interventions were delayed or missed entirely. This had a particular impact on care home residents due to the prevalence of chronic conditions and complex health needs amongst this population. It is CBFJC's belief that this contributed to a significant decline of care home residents through worsening health conditions, undiagnosed illnesses, and, in some cases, preventable deaths.
87. The emotional toll and ethical strain on care home staff were immense, as they were left to manage pain and suffering that could have been alleviated with proper intervention. Ms Hough felt that nobody was speaking up for her patients [Day 2/131:12], and she wrote to WG officials on 4 May 2020, as a *"very distraught tired nurse feeling helpless"* setting out the desperate position facing care homes residents and the disgraceful disparity between their treatment and that of NHS patients: *"We have no oxygen on site...I have tried to get GP's to prescribe it but they give us end of life drugs instead. Relatives would be horrified if they could see how poor their relations are being treated in care homes, but because there is no access to visitors they are not witnessing this...As a patient's oxygen saturation level drops with this disease they are gasping for breath, and we cannot give any oxygen relief at all, and as this is the only treatment for COVID19 this is disgraceful, it is 'on tap' at a hospital so patients in hospital will already [be] receiving better care than what we can*

give at a care home" [INQ000598472].

88. The stark reality is that most Welsh care homes were wholly ill-equipped to look after residents who were very unwell or dying. The Inquiry heard from Gillian Baranski (CIW) that the majority of Welsh care homes did not provide nursing care: *"790 of our care homes [out of 1,053] didn't have nursing and therefore they didn't have access to end-of-life medication and to oxygen"* [Day 5/191:1]. This structural limitation was known to WG and should have informed urgent resource allocation. Instead, WLGA survey results show that 59% of local authorities in Wales reported that residents were not receiving adequate medical treatment and 47% reported that necessary transfers to hospital were not undertaken [INQ000613908_0074-0075, §§193-194]. There is no evidence that these issues were a priority for WG.
89. Routine inspections in care homes by CIW ceased in March 2020, which resulted in a lack of monitoring and understanding of what was happening in those homes. Helen Hough's evidence was that, *"there was no comprehension on the part of the local authority, the [Local Health Board] or CIW as to what we were dealing with on a day to day basis. We were so busy, all the time. And when we started to lose patients, it was devastating for all of us"* [INQ000587639_0013, §62].
90. CBFJC recognise that an initial suspension of inspections in March 2020 was reasonable, but given the desperate and frightening circumstances that care home residents and staff were facing, the suspension of routine inspections throughout the pandemic was inappropriate and CBFJC agree with the evidence of Dr Allen (British Association of Social Workers) that the need for monitoring and inspection was heightened rather than reduced [Day 4/48:21-22]. Gillian Baranski told the Inquiry that by June 2020, CIW inspectors had available sufficient PPE and testing to enable more inspections [Day 5/160:11]. However, routine inspections were not reintroduced in Wales until 4 August 2021 and Wales recorded the lowest number of inspections across all UK nations during the financial year 2020-2021 - just 20% of the number of inspections undertaken in the year 2019-2020 [INQ000587847].
91. Data challenges were another significant issue affecting the care sector and Chris Llewelyn (WLGA) stated, at §124 of his statement, that *"During the pandemic there were several data-related challenges that impacted decision-making, service delivery and resource allocation. This included data availability and collection issues, where there was a lack of real-time data on care home residents, staff absences, and infection rates which made it difficult to respond quickly to outbreaks"* [INQ000613908_0050]. While care homes were required to notify CIW of suspected or confirmed Covid-19 in staff or patients from 12 March 2020 [INQ000569773_0062, §189], testing capacity, patients not exhibiting 'common' symptoms, and asymptomatic infection meant that recorded rates of infection and deaths from Covid were inevitably inaccurate. There were also known difficulties reconciling data held by CIW on the numbers of cases and outbreaks in care homes with

PHW data on notifications of infectious diseases [INQ000569773_0012, §39] [INQ000587702_0037-38, §§123-127]. There was no apparent priority in addressing these issues and Professor Bolton's rapid review for care homes in Wales, published in September 2020, highlighted the challenge of "*a large number of public bodies all looking to play their role in the system but sometimes 'tripping over' each other to collect data and to understand what was happening in specific care homes without obvious benefits to the care homes themselves*" [INQ000253708_0009]. This inevitably led to a lack of accountability for the protection of those in care homes, which must be addressed.

92. Older people in Wales contributed more than any other group to the fabric of Welsh society, and yet their needs and rights were overlooked and dismissed time and again. Despite knowing that older people in residential care and nursing homes were the most vulnerable to Covid-19 infection, they were consistently deprioritised in the decisions taken by WG and public bodies. Simply because of age or cognitive impairment, they were written off as deserving of care, protection or adequate treatment. CBFJC agree with the closing remarks from Professor Vic Rayner, that "*we need those decision makers to think about social care first. It's not Cinderella. It's not the handmaiden of the NHS. It's a vital public service that's the backbone of communities. And we forgot that then and we must never do that again*" [Day 4/119:14].

Fourth - failure to prepare for the second wave and to learn lessons

93. The second wave of the pandemic saw further huge loss of life in Welsh care homes. ONS data analysing deaths across England and Wales shows that Wales had the highest proportion of Covid related deaths of care home residents in Wave 2 - at 28.8% [INQ000509882_0006].

94. It was well known that there would be a second wave of Covid-19 with the potential to be more severe than the first. The current Chief Scientific Adviser to the UK Government, Professor Dame Angela McLean, described in her witness statement to Module 2 that the September and October 2020 period was "*the worst moment of the pandemic*" [INQ000309529_0046], because, "*we could see what was coming and could not understand why the government did not act upon the science advice by introducing effective interventions*" [INQ000309529_0044], and "*We could see infection rates rising. We knew that a large portion of the population had still not been infected so were still susceptible. It was therefore inevitable that the epidemic would grow larger*" [INQ000309529_0045].

95. The monthly reporting to CIW [INQ000198645 tab 9] shows how the numbers of suspected and confirmed Covid-19 deaths in care homes in Wales fell to single figures in July and August. This 2020 summer lull provided an opportunity to take steps to prevent further significant loss of life. However, not only was this opportunity squandered, but decisions were taken that placed care home residents at increased risk, resulting in further devastating loss of life with 1,138 suspected and confirmed Covid-19 deaths in Welsh

care homes in the second wave (October 2020 to February 2021) and a peak of 460 deaths in January 2021.

96. On 25 November 2020 WG decided to intentionally delay the vaccination of care home residents, contrary to the explicit recommendation of the Joint Committee on Vaccines and Immunisation (JCVI) [INQ000493687_0023, §95]. The reason that care home residents were the first JCVI priority cohort for vaccination was because of their extreme vulnerability and because vaccination had such pronounced benefit, as explained by Professor Wei Shen Lim in his evidence [Module 4/Day 8:89/7-90/6]: *“the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age care home, we would protect one life. The same number needed to vaccinate to prevent one person from dying in a 65-year old cohort was 1,000, and of the number needed to vaccinate -- to prevent one life -- save one life in the 50-plus cohort is 8,000. So by the time we get to children and young people who have no underlying health conditions, then the number needed to vaccinate to prevent one adverse outcome -- clinical outcome, not safety outcome -- is in the many tens of thousands”*.
97. The requirement for ultra-low freezer capacity for the Pfizer vaccine was known from at least 25 August 2020 [INQ000501330_0018 §67] and the failure to procure the necessary freezer storage and develop a delivery plan for care homes in the four months to December, given the known risks to life, is inexcusable. All UK nations faced this challenge, but the response of WG was by far the least effective. Vaccinations in Wales commenced on 8 December. However, by 26 January 2021 only around 67% of care home residents had received their first dose [INQ000508504]. By 16 February, at the tail end of Wave 2, this number had risen to just 82% [INQ000410143].
98. In contrast, Scotland reached this level over a month earlier on 12 January 2021 [INQ000376337] and Northern Ireland delivered vaccinations to care home residents on 8 December 2020, the first day of the programme, and by 26 February 2021, all residents and staff in their care homes had been offered a first and second dose [Day 1/166:14-24]. The WG’s departure from JCVI advice was discussed in a Cabinet Office meeting on 12 January 2021 [INQ000088889] when it was noted that Wales had taken a different approach to other nations by prioritising NHS staff for the Pfizer vaccine.
99. This poor performance was accompanied by the usual spin and false statements that CBFJC has come to expect of WG. In the witness statement of Mark Drakeford to Module 4, it is stated, *“On 18 January 2021, during a BBC Radio 4’s Today programme I was asked about the vaccine roll out in Wales and the suggestion that Wales had vaccinated fewer proportion to its population than other nations of the UK. I explained that there was a very marginal difference in the vaccination statistics but in any event, I explained that the supplies of the Pfizer vaccine had to last until the beginning of February*

and would not be used all at once. I explained that it would be logistically damaging to use the vaccine all in the first week and the sensible thing to do was to vaccinate over the period that we had to vaccinate, so that the system could absorb it. At no time was the Pfizer vaccine withheld. All Health Boards were received doses of Pfizer which were successfully deployed in a manner to minimise wastage, which at that time was less than 1%. I committed to vaccinating all four priority groups by the middle of February and this was achieved” [INQ000474420_0030]. This statement is incorrect in two material respects: first, the statement, “*at no time was the Pfizer vaccine withheld*” is not correct, and vaccines were deliberately withheld from care home residents by a decision of the Minister for Health and Social Care, Vaughan Gething, on 25 November 2020; second, the statement, “*I committed to vaccinating all four priority groups by the middle of February and this was achieved*” is also not correct, with only 82% of care home residents being vaccinated by 16 February 2021.

100. Given that the case fatality rate among infected unvaccinated elderly care home residents was one in three, and that vaccine effectiveness for this group against death from Covid-19 was established at between 64% and 96% for doses one and two, rising to 97.5% after dose three [INQ000544935]⁶, this represents yet another failure by WG to implement an essential safety measure until it was too late to avoid mass fatalities, and shows how little they learned from Wave 1.
101. Another decision that placed care home residents at increased risk was to discharge hospital patients with low level positive tests to care homes from 15 December 2020. The risk was described as low; however, there remained uncertainty. And there had been concerns about the possibility of such a reversal from as early as 3 July 2020, as described at §102 of the witness statement of Claire Sutton of the Royal College of Nursing: “*Helen Whyley wrote to Dr Andrew Goodall, Director General Health and Social Services and Chief Executive NHS Wales, after being given the opportunity to comment on the document NHS Wales Covid-19 Operating Framework - Quarter 2 (20/21) [CS/013 - INQ000525175]. The RCN was pleased that there was still a focus on older people in care homes and that their needs were being met. We felt, however, that we were missing an assurance that any older person being admitted to a care home or returning from hospital would have tested negative for Covid-19 prior to their transition.*” [INQ000587657_0027].
102. The fact that the WG was prepared to take risks with the lives of care home residents by discharging positive testing patients into care homes at a time when deaths in care homes were rising rapidly, having already suspended vaccinations, and knowing the devastating impact of infection once it entered a care home, disproves the claims of the WG

⁶ Duration of vaccine effectiveness against SARS-CoV-2 infection, hospitalisation, and death in residents and staff of long-term care facilities in England (VIVALDI): a prospective cohort study’ published in the Lancet in July 2022

that the most vulnerable in Wales were at the heart of their decision making.

103. CBFJC were also promised a care home investigation by Mark Drakeford during a face-to-face meeting with him at WG buildings in August 2022. He agreed that “just because it is difficult, it doesn’t mean it shouldn’t happen”. However, no investigation was commissioned, and instead a 13-page good practice guide, ‘Undertaking Factual Reviews for Residents Who Acquired COVID-19 Within the Care Home Sector’⁷ was issued to care home providers in October 2023. Not only does this guidance place the onus of investigation on care home providers, but there is also no duty or requirement to conduct an investigation, meaning few, if any, will have been performed, and with no means of considering the national picture, nor the role and actions of the WG and other public bodies. When this guidance was published, CBFJC immediately wrote to WG on 26 October 2023 to complain that the First Minister had agreed to a Welsh care home investigation, and that the guidance failed to deliver on this agreement. Further, that what was required was an investigation in Wales to determine why care homes were not prepared for an airborne and asymptomatic virus, why they had so many cluster outbreaks, why PPE, oxygen and testing was unavailable, the impact of staff movement between different care home premises, and a definite account of the numbers and causes of death of those who died over the pandemic while in care homes, particularly in the absence of any inquests. The failure of WG to hold such an investigation is typical of WG in making false promises, avoiding scrutiny of their actions, and failing to seek to learn from their mistakes.

Conclusion

104. The anger felt by bereaved families in Wales is not just rooted in the loss of their loved ones, but in the neglect and indignity that they suffered, in the WG’s refusal to accept their mistakes, and in the ineffectiveness of organisations tasked to protect care home residents. The WG needs to take responsibility for what went wrong so that there can be learning and improvement and so that families can begin to move on.

105. Despite challenge from organisations such as CIW and the OPCW, they were unable to effect meaningful change during the pandemic. CBFJC therefore seek a recommendation that will provide genuine independent scrutiny of the care sector in Wales allied with powers to hold those responsible for the provision of care accountable.

106. CBFJC conclude this closing statement with the words of Helen Hough, in her email to the Welsh Government on 4 May 2020, in which she stated “*I do hope, when this is over, this is all thoroughly investigated, because I and many other Managers will be stating what a diabolical shambles this is in Wales, and possibly causing many unnecessary deaths...*” [INQ000598472].

⁷ <https://www.gov.wales/sites/default/files/publications/2023-10/undertaking-factual-reviews-for-residents-who-acquired-covid-19-within-the-care-home-sector.pdf>

COVID 19 INQUIRY
MODULE 7: TEST, TRACE AND ISOLATE

WRITTEN CLOSING STATEMENT
OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU (CBFJ CYMRU)

Introduction

1. This closing statement is focussed on matters affecting Wales and the implementation of the Test, Trace, Protect (Wales) programme (**TTP Wales**). There were significant differences in the Test, Trace and Protect policies employed in Wales, with numerous and substantial variances in approach, resources and deployment across the four UK countries throughout the relevant period (January 2020 until February 2022).
2. The CBFJ Cymru's shared lived experience of TTP Wales was one of a chaotic system where policies were ineffective, messaging was confusing, and implementation was inconsistent, late, contradictory and at times incoherent. Decisions in Wales were often different or taken later than in the other UK countries.
3. As the Inquiry is aware, the issue of nosocomial infections and deaths is a major concern of the CBFJ Cymru, many of whose loved ones died from infection acquired in a hospital or care home setting in Wales. The delayed and chaotic nature of the Welsh Government's implementation of TTP Wales contributed significantly to these tragic circumstances.
4. The submissions of the CBFJ Cymru are set out in accordance with the topics identified in the Inquiry's List of Issues (**LoI**):
 - Decision making
 - Infrastructure and capacity
 - Key policies

List of Issues 1: Decision-making, including the engagement between UK Government and the devolved administrations in relation to TTI systems

5. At a ministerial level, the Welsh Government frequently suggested they were given insufficient warning as to UK Government policy decisions. Mr Gething told the Inquiry, "*we were finding out things as they were being announced...on the hop*" [6/126/8-15]; Mr Drakeford commented that "*inevitably there were frustrations*" [6/185/3]. The CBFJ

Cymru is concerned to ensure that such complaints are approached with caution, given the Welsh Government's desire for political point-scoring apparent in this and other Modules, and the evidence of good cooperation and collaboration between the Chief Medical Officers and Chief Scientific Advisors (referred to by the CMO for Wales, Sir Frank Atherton, as "excellent cooperation and information sharing" [INQ000575984_0060]).

6. That said, there is at least once instance where the lack of engagement between UK Government and the Welsh Government raises legitimate questions: the setting up of Deloitte's mass testing site in Cardiff City Football Stadium.
7. PHW said this of the mass testing centre [INQ000587250_0075-76]:

335. ...A call took place [with Deloitte] on 1 April 2020, during which we were advised that Deloitte had set up a drive through mass sampling facility at Cardiff City Stadium and it would be ready to accept keyworkers for testing from 2 April 2020.

336. This was the first time that Public Health Wales was made aware that the mass sampling centre had been established. The Welsh Government was also not aware of its establishment until this time.

337. Following internal discussions, we spoke with Deloitte again on 2 April 2020 and asked them to "step down" the facility until Public Health Wales had had further conversations with the Welsh Government.

8. Jo-Anne Daniels, Director of TTP Wales from April 2020 onwards, confirmed in her evidence to the Inquiry that the Welsh Government was indeed apparently unaware of the mass testing centre [6/82/6-9].
9. Dominic Cook was a partner in the Major Programmes Team at Deloitte. He explained that Deloitte's role was to identify and build regional testing sites (RTS), such as the one in Cardiff. It was not Deloitte's role to seek approval from or liaise with the Welsh Government; Deloitte understood that the DHSC was responsible for such matters. Deloitte did, however, liaise directly with Cardiff City Council, and indeed had signed a lease with them in order to set up the RTS in Cardiff [5/155/24-156/5].
10. It is almost inconceivable that the Welsh Government and PHW - the lead agency responsible for public health in Wales - were unaware of the setting up of the largest mass testing site in Wales. If that was indeed the case, then it points to serious

communication failures between the UK Government and the Welsh Government. More relevantly for Wales, it points to a serious communication failure within government structures within Wales: how could it have come to pass that the Welsh Government and PHW were so adrift from the decision making of Cardiff City Council on such a key public health development during the pandemic? The communication failures take on a particular significance given the Welsh Government has repeatedly sought to impress upon the Inquiry in its 'lessons learned' the virtues of small governance, and the good levels of cooperation across the different levels of government. The debacle surrounding Cardiff RTS exposes the lack of substance of such claims.

11. Whatever the cause of the failure, it was, of course, the people of Wales who suffered the consequences. The site's opening was delayed by a week at a critical time in Wave 1 of the pandemic (April 2020), whilst PHW resolved issues relating to sampling methodologies and access to testing results (which, due to a lack of integrated systems, could not be seen on patient's records) [INQ000587250_0076, §339]. These are delays which could and should have been avoided, had basic communication channels existed between Cardiff City Council and PHW/Welsh Government.

List of Issues 2: Infrastructure and capacity

12. The Inquiry will consider what systems were in place to rapidly scale up, including in relation to test development, diagnostics, and national and local tracing.
13. The CBFJ Cymru is concerned that there was a limited ability to trace in Wales, let alone an ability to scale up testing and tracing systems in Wales. Despite numerous pandemic preparedness exercises in the last two decades, the Welsh Government did nothing to build capacity in testing and tracing systems. The CBFJ Cymru set them out here as they provide important context for the failures to scale up effectively.

2003: Exercise Shipshape [Module 1 - INQ000235217]

14. Exercise Shipshape was an exercise carried out in June 2003. Its aim was to explore the contingency plan in the event of an outbreak of Severe Acute Respiratory Syndrome (SARS) in South West England and Wales. The concerns raised in Shipshape remain as relevant today as they were in 2003, as the findings on key objectives demonstrate:

- 1. To explore the capabilities of local healthcare systems in coping with an increasing number of SARS cases.***

- *There was a need to think about safety procedures and places for*

assessing patients.

- *Staffing resources would be problematical*
- *Should one hospital in the area be designated an infectious diseases receiving hospital? Should it be geared up now?*
- *There may not be adequate ITU bed capacity and protective equipment*
- *Decontamination advice will be given by hospital infection control teams who should have a policy in place - there is a trust-wide policy in place (Wales)*
- *There are health & safety issues around air conditioning units*

2. To explore control of infection guidelines, including isolation procedures and communication protocols.

- *Decontamination protocols (e.g. WHO/CDC) and all related issues to be dealt with subsequently by a taskforce*
- *Communications protocols apparently already exist between PCTs and SHAs, but were not readily apparent*
- *Guidelines may need revision, in light of exercise ...*

4. To explore contact tracing arrangements and co-ordination of data communication.

- *In a non-exercise situation, contact tracing would be very time and labour intensive. Who would carry this out?*
- *Consider strengthening staff training to cover contact tracing.*
- *Who holds the operational data? There needs to be an integrated national database at Colindale to provide information for WHO, SW Epidemiology and CDSC*

5. To identify resource requirements.

- *Does NHS have capacity?*
- *There is a need for surge capacity and relief arrangements*
- *Lack of personal protective equipment (in this context includes gloves, gowns and TB- quality facemasks).*
- *Clarify PPE stocks and ensure safe storage*
- *Look at emergency department capacity*
- *Look at ICU capacity [INQ000235217_0004].*

15. The CFBJ Cymru observe that, had learning from Exercise Shipshape been implemented, Wales would have been in a far better position by the time of the Covid-19 pandemic some 17 years later. Instead, there appears to have been no

learning whatsoever. As Anna-Louise Marsh-Rees, co-leader of CBFJ Cymru, said in her evidence to the Inquiry: “*there were a number of recommendations that were made, including being able to effectively contact, trace and isolate. Clearly none of that seemed to be taken on board in subsequent years*” [1/146/12]. Indeed, such was its perceived insignificance that the final report of Exercise Shipshape was disclosed by the Welsh Government one month after the conclusion of Module 1 (and thus was not addressed by the Inquiry during the public hearings considering preparedness in Module 1).

2009: Exercise Taliesin [Module 1 - INQ000128976]

16. Exercise Taliesin took place in April 2009. The aim of *Exercise Taliesin* was to test the Pan-Wales Response Plan and influenza pandemic plans by live exercise across Wales. Exercise Taliesin exposed a number of gaps in plans which “*need to be addressed ahead of a more serious pandemic*” [INQ000128976_0013]. Of particular concern was the social care sector:

Social Care

Although considerable progress was made in developing resilience within the social care sector during the response to swine flu further work is required to enhance the engagement with, and preparedness in, the independent care sector [INQ000128976_0014].

17. The de-brief recorded the following under the heading, ‘What Next?’:

The completed report will be circulated to all Local Resilience Forums for them to consider the outcome and the recommendations and to translate these into appropriate actions to further develop pandemic flu planning at the LRF and organisational levels. This will compliment the lessons learnt agreed in the individual LRF de-briefs and those produced for each LRF by Gold Standard. Individual agencies will also have their own de-brief reports to draw upon in this process.

The Wales Resilience Partnership Team will consider the recommendations which can be taken forward at an all-Wales level to help support local pandemic flu planning.

It is likely that a more detailed review of the swine flu response will be undertaken at all levels following the end of the pandemic. This will develop further recommendations to help improve planning [INQ000128976_0006]

18. None of this appears to have been done. The Wales Resilience Partnership Team agreed to set up the Wales pandemic flu task and finish group to consider recommendations from the 2009 swine flu pandemic. As confirmed in the oral evidence of Dr Andrew Goodall in Module 1, that group did not finish its task and the recommendations were not all fully implemented [13/95/9-10].

2013: the Pollock Review

19. A 2013 review called the Pollock review investigated why lessons were not being learned. As a result of that review, the Wales Learning and Development Group was formed, and a decision was taken to apply a Joint Organisational Learning strategy. Nothing happened.

2014 and 2016: Exercise Cygnus [Module 1 - INQ000187149]

20. Exercise Cygnus was the Welsh Government's pandemic flu exercise. The report in October 2016 'Exercise Cygnus – Wales De-Brief Report' [INQ000187149] set out a list of recommendations. Of particular note were the following:

Recommendation 1 - All organisations were asked to review their pandemic plans regarding health countermeasures to ensure they remained robust;

Recommendation 2 - All organisations to ensure there is sufficient awareness within their organisations of what is held within the Welsh National Stockpile and how these would be distributed to them

Recommendation 3 - All organisations to review their local delivery points and antiviral collection points to ensure they remained current and to share this information with Welsh Government

Recommendation 4 - The Pan-Wales Response Plan should reflect the fact that Welsh Government needs to establish a Battle Rhythm early for all situation reporting to assess the impact of any emergency on the LRF areas and set out clearly and early what information is required... [INQ000187149_0004-0007].

21. The Inquiry will recall from Module 5 that a failure to maintain adequate and in date stockpiles led to (amongst other things) inadequate supplies of PPE and a completely chaotic distribution system – such that local hospitals and care homes did not receive what they needed. The Wales Resilience Partnership Team delegated the responsibility of implementing recommendations to yet another body, the Wales Pandemic Flu Preparedness Group. However, the workstreams which were identified after Exercise

Cygnus in 2016 were not all fully implemented because the body designed to ensure implementation, the Wales Pandemic Flu Preparedness Group, did not sit after January 2018. Mr Drakeford in Module 1 explained that this was because resources were needed elsewhere due to Brexit planning. Such explanations lack substance: Wales has suffered from two decades of failures to implement recommendations from its learning exercises.

2016: Exercise Alice [INQ000001213]

22. Although Exercise Alice focused on England, it was attended by a representative of Welsh Government who, as such, would have been aware of the learning and recommendations. This is particularly relevant as the exercise examined the response to MERS-CoV. The following recommendations are of critical importance:

- *Develop a MERS-CoV serology assay procedure to include a plan for the process to scale up capacity.*
- *Produce a briefing paper on the South Korea outbreak with details on the cases and response and consider the direct application to the UK including port of entry screening.*
- *Explore the capability for contact tracing and quarantining of possible MERS-CoV cases:*
 - *Produce an options plan using extant evidence and cost benefits for quarantine versus self-isolation for a range of contact types including symptomatic, asymptomatic and high risk groups.*
 - *Develop a plan for the process of community sampling in a MERS-CoV outbreak.*
 - *Develop a live tool or system to collect data from MERS-CoV contacts.*
 - *Research, review and identify good practice for definitions for close-high risk contacts and recommend a definition for MERS-CoV.*
 - *Prepare a FAQ for MERS-CoV close/high risk contacts.*

2019: TTP scheme Llanelli

23. The Welsh health system had experience of a TTP scheme following the outbreak of a respiratory disease (tuberculosis) in Llwynhendy, Llanelli, in 2019. Mr Gething, in his evidence to the Inquiry in Module 2, described the system as follows:

we had a highly efficient contact tracing system and service for small to modest outbreaks. So I think I've given the example of the TB outbreak in Llwynhendy that

took place, and actually our contact tracing system there was really good and really efficient but actually the scale of what was required – that wasn't really contemplated as a learning point that was ever brought to me after Cygnus... [Module 2 11/47/12].

24. Similarly, Mr Drakeford in his Module 2 witness statement cited the TTP-type scheme for a tuberculosis outbreak in Llanelli as evidence that Wales has a “*pre-existing infrastructure that had served the nation well*” [INQ000575983_0017, §§59-62].
25. But Mr Gething and Mr Drakeford are wrong to point to this experience as a success story. A report by PHW into the management of the TB outbreak found that there were “*serious failings*” linked to contact tracing, with the result that “*infected people were unrecognised and developed active disease, passing the infection on to others*”.¹ Cases linked to the outbreak in 2010 continued to be identified in 2019.
26. The CBFJ Cymru are frustrated that exercises took place to no effect: recommendations were not implemented leaving Wales vulnerable when the pandemic arrived in 2020. In short, Wales’ starting point was wholly inadequate. It had no hope of scaling up effectively.

‘Scaling up’ testing in laboratories in Wales

27. As was acknowledged by the Welsh Government in its evidence to the Inquiry, Wales lacked the ability to scale up test and trace and effectively. The reason given was that Wales had not anticipated test and trace on the scale required by Covid-19. This explanation exposes a lack of preparedness. However, the CFBJ Cymru is also concerned to ensure that the decision-making of the Welsh Government as to scaling up is scrutinised. In particular, the CBFJ Cymru asks whether better use should have been made of existing testing infrastructure of PHW laboratories in Wales, in the period prior to the establishment of mass testing sites.
28. Here the evidence of Sir Paul Nurse and his Dunkirk metaphor is apposite:

We needed the big ships but we had to appreciate that they would take time to be put in place and that we had to do something before they could get in place, and they would probably always be a bit slower.

¹Llwynhendy Tuberculosis Outbreak external review report’, 2 December 2022, jointly commissioned by PHW and Hywel Dda University Health Board.

The little boats, on the other hand, such as the Crick, could produce, as I've explained, much more rapid turnover in getting the data back, and would be very essential at the beginning of a pandemic because if you don't know where the infection, is you can't actually take any ways of preventing it. So it's absolutely critical [4/12/7-18].

29. Sir Paul's evidence was that had the smaller boats - the laboratories which were directly connected to hospitals and care homes - been utilised effectively, they would have "easily managed" routine testing of health care workers and care home workers in the early stages of the pandemic. The effect, had this been done, would have been to protect healthcare workers and vulnerable patients alike.

...we could have scaled up to around 10,000 in a month if we'd had the money. And given what I've already said, there's nothing that special about the Crick except we were prepared to do it and to do it very quickly. That could have been rolled out, using our protocols, to 30, 40, 50, maybe more places in the rest of the UK. I'm guesstimating there, I haven't actually counted them, but I'm thinking of research universities and other research institutions.

So if you just do the simple maths there, you can see that, within a month or two, we could have had 100,000 to 200,000 tests which would be turned around every 24 hours, locally set up. And that, I think, would have been a very effective way of dealing with the early days of the pandemic [4/21/8-22].

30. PHW produced a witness statement in which they set out the testing capacity at the start of the pandemic, including 13 PHW laboratories. However, there appears to have been no consideration as to scaling up the use of these laboratories – as the Crick Institute envisaged – in the early stages. Given Wales' high rate of nosocomial infection, this would appear to have been a missed opportunity and the likely consequence of a complete failure to plan for such a scenario.

List of Issues 3: Key policies

31. This section sets out key concerns of the CBFJ Cymru in respect of the TTP Wales. The topic, in particular the testing aspect of it, lies at the heart of the CBFJ Cymru's concerns.
32. Despite numerous pandemic preparedness exercises in the last two decades (described above), the Welsh Government did nothing to build capacity in testing systems. And,

when the pandemic arrived, this unpreparedness translated to a refusal to recognise the value of testing and to ensure it was prioritised.

33. Concerns regarding different aspects of the policies are addressed below.

A. Testing

(1) Delay in recognition by the Welsh Government of the value of asymptomatic testing

34. The Inquiry has heard expert evidence about when the scientific community acknowledged asymptomatic transmission.
35. Professor Christopher Fraser, Professor of Infectious Disease Epidemiology, told the Inquiry that the evidence of asymptomatic transmission “*emerged quite clearly throughout February and March 2020*” [2/199/19-20]. And at paragraph 19 of his witness statement, he explains:

*During February 2020, after discussions with several colleagues, it became clear that it would be useful to model TTIQ in the context of the new virus... A **startling difference** [emphasis added] that became immediately apparent from case reports was that many people appeared to be infected by asymptomatic source cases; over 70% in the case reports from China CDC. I contacted a colleague in Hong Kong to discuss this and confirm the validity of the results, which he did. We also consulted the dashboard of the Singapore ministry of health. They found that whilst many people seemed to have asymptomatic source cases, these source cases themselves became symptomatic after a few days. This proved that transmission was likely happening before people became symptomatic. Our estimates rapidly converged on about **50%, half of all transmissions**, [emphasis added] coming from cases that were not symptomatic at the time of transmission [INQ000475153_0007].*

36. Sir Paul Nurse, director at the Crick Institute, told the Inquiry there was “*ample evidence, actually from very early on*” of asymptomatic transfer, citing studies from China, Hong Kong, Italy, the cruise ship Diamond Princess [4/32/16-19].
37. Professor Harries (PHE and UKHSA) supported these views and told the Inquiry:

...asymptomatic testing and the risks were completely understood, I think, in March...at the start of April...there was a particular study in the US, in the Seattle

care home, which gave a lot of strong evidence with very good data and denominator factors of asymptomatic transmission, and then PHE actually did what's known as the Easter 6 study...which gave us...homegrown UK figures for the first time, which were really robust...I think it was generally around April time...when the reality of the proportion of cases...of asymptomatic transmission was recognised [10/142/6-21].

38. The Seattle care home study referred to by Professor Harries is at INQ000224063. It was posted as an early release on the website of the Morbidity and Mortality Weekly Report on 27 March 2020, and formally published on 3 April 2020. The report found that once Covid-19 was introduced into a nursing facility, rapid transmission occurred, and that of the 30% of residents at a particular facility that tested positive, approximately half were asymptomatic on the day of testing.
39. The PHE Investigation of SARS-CoV-2 outbreaks in six care homes in London over the easter weekend (13-17 April 2020) found that of the 218 residents, 107 (49.1%) were SARS-COV-2 positive and of these 107 residents, 51 (47.7%) did not develop any symptoms during the two weeks before or after swabbing. 20% of the staff tested positive, of whom only approximately 20% were symptomatic [INQ000320602].
40. On 14 April 2020, the 'Go Science' advice confirmed that asymptomatic infection, "*is common and represents a large proportion of disease transmission...Intensive track-and-trace testing efforts, including of asymptomatic individuals, are thought to be core to the successful disease control efforts in South Korea, Hong Kong, and Singapore...*" [INQ000087177_0001-2].
41. This was the same date that Sir Paul Nurse and fellow scientists at the Crick wrote to Mr Hancock to urge asymptomatic testing of health care workers – a priority cohort given their potential exposure to the virus and given their proximity to vulnerable people:

We followed the Committee's debate on the adequacy or otherwise of testing capacity within the NHS, but were surprised that, as far as we could hear, no mention was made in that assessment, of the need to test asymptomatic or oligo-symptomatic individuals, be they health-care workers or patients. This is of great concern in view of emerging evidence that a high proportion of infections are asymptomatic, obviously entraining a high risk of transmission between and among HCW and patients...

...Our perception is that, at present, there is reticence about doing more widespread testing of health-care workers. It will clearly be expensive and yet another challenge for hospitals that are already under pressure. Some have privately expressed their concern that making a positive diagnosis in asymptomatic health-care workers who might otherwise continue to work will deplete staffing levels at a time of need. Whilst perhaps understandable, these concerns are not productive in terms of the overall goal of controlling the epidemic. Rather it will result in recurrent problems of seeding fresh outbreaks with staff absences and the potential for infecting non-Covid patients in the health-care environment. Importantly, we consider that these concerns can only be overcome by a clear central directive from you as Minister [INQ000587060_0001].

42. Mr Hancock told the Inquiry that 14 April 2020, the date of the Go Science advice, was the date from which the UK government started making decisions on an assumption of asymptomatic transmission [8/32/23-25].
43. The following day, on 15 April 2020, the Lancet published evidence [INQ000587051] outlining the case for routine testing of healthcare workers given asymptomatic transmission. The article reported:
- A study of asymptomatic infection on the Diamond Princess cruise ship showed 51.7% were asymptomatic at the time of testing;
 - China's National Health Commission recorded on 1 April 2020 that 78% of positive cases (in a study) were asymptomatic;
 - Healthcare worker testing could reduce in hospital transmission – 41% in Wuhan got it in hospital. At the Royal Gwent Hospital, approximately half the A&E staff tested positive;
 - There was a powerful case in support of mass testing of both symptomatic and asymptomatic healthcare workers to reduce risk of nosocomial transmission and asymptomatic testing was “critical” to pursuing an exit strategy [INQ000587051_0002].
44. However, Wales was much slower to take account of the serious risk of asymptomatic transmission within its decisions and policies, despite being aware of the dangers this posed to vulnerable people. For example, on 24 March 2020 in the Senedd, the former First Minister, Mark Drakeford warned, “...most people will experience a very mild episode of this illness...The problem is that while you are asymptomatic you could be passing the virus on to somebody who is much more vulnerable” [INQ000420992_0020].

45. On 29 March 2020, Public Health Wales advised that “[i]f new...or existing residents do not have any symptoms...there is no value in testing for the presence of coronavirus” [INQ000336344].
46. Mr Drakeford uses almost identical language in the Welsh Senedd:
- a. On 29 April 2020, Mr Drakeford told the Senedd when asked about routine testing in care homes, that “*the clinical evidence tells us that there is **no value** in doing so.*”
 - b. On 6 May 2020, he similarly told the Senedd that he had not seen “*any evidence*” that asymptomatic testing had any “*clinical value*” in homes where there was no coronavirus in circulation.
47. Explanations for these bizarre statements were offered by Mr Gething - who referred to the “*cut and thrust*” of the debating chamber [6/166/16] – an unconvincing explanation given Mr Drakeford was clearly following the party line developed earlier in March, and then doubled down on the claim on 6 May. Dr Howe also attempted to defend Mr Drakeford by pointing out that the second statement in the Senedd was conditional on there being no coronavirus in circulation [9/129/9-17]. However, CBFJ Cymru submit that the views of Peter Halligan, Chief Scientific Advisor for Wales as expressed by Robert Hoyle (Head of Science for the Welsh Government Office for Science) are to be preferred. He wondered what “*the rationale, evidence and advice*” [PHT000000073_0046] was behind Mr Drakeford’s comments.
48. However one interprets these comments, one thing is clear: there was no change to the Welsh Government’s baseline flawed assumption until mid-May.
49. The Welsh Government point to the “*new*” SAGE advice of 12 May 2020 [INQ000587349_0048, §167] that extensive asymptomatic testing in care homes was *crucial*, to justify their delay in not introducing partial routine testing in care homes until 16 May 2020 (not expanded to all care homes until 15 June 2020). But this entirely misses the point – this was not new knowledge or advice at all as clearly demonstrated above.
50. The Welsh Government had the scientific evidence. Whatever the claimed difficulties in communication at Ministerial level, there was a high degree of collaboration between the UK CMOs, Chief Scientific Advisers and public health agencies. Thus, Wales would have been aware of the evidence in the scientific community, known by Professor Fraser, Sir Paul Nurse, Professor Harries, as referred to above, and in which respect CBFJ Cymru

asks the Inquiry to find that the scientific evidence was sufficiently strong as at 3 April 2020 (the date of publication of the Seattle care home study) to require government decisions and policy to be premised from this date on the assumption of very significant levels of asymptomatic transmission.

51. Further, the SAGE meeting minutes (at which the Chief Scientific Adviser for Wales was represented) demonstrate that the issue of asymptomatic transmission (and the related need for testing) was recognised throughout April and was not “new” advice on 12 May 2020, as claimed by the Welsh Government:
- a. 14 April SAGE 25 (the day of the GO Science report advising of the evidence of widespread asymptomatic transmission and that symptomatic-only based screening will miss cases) – at §§8-11: warning of significant transmission in hospitals and care homes and the need for increased testing in these settings.
 - b. 16 April SAGE 26 – at §§3, 31, and 33: *“Testing is an important part of controlling transmissions in hospitals and care homes”*; SAGE advises that the recommendations of the Nosocomial Working Group to reduce nosocomial spread should be adopted immediately in a coordinated fashion across all 4 nations, and *“SAGE advised that longer-term thinking on using separate sites for confirmed Covid-19 patients should be considered - as well as repeat testing of patients testing negative”*.
 - c. 23 April SAGE 28 – §§10-14: testing to commence of asymptomatic patients and staff and a testing strategy to reduce the spread in care homes is required.
 - d. 28 April SAGE 29 – §9: the proportion of cases acquired through nosocomial transmission may be increasing again. SAGE noted work underway to test new admissions to hospital as well as asymptomatic staff.
 - e. 30 April 2020 SAGE 30 – §§11-15: variation in levels of nosocomial transmission, with a rebound and persistent rise in some Trusts...significant transmission in care homes...a substantial surveillance system is needed to reduce transmission...A recent NHS study suggests a positive test rate among asymptomatic healthcare workers of 5-6%.
 - f. 5 May 2020 SAGE 33 - §2: *“SAGE advises that based on current data, focus should be maintained on reducing transmission in health and care settings. Urgent action should be taken in establishments where relevant measures are not already in place, in line with previous advice (such as avoiding movement of patients or staff between establishments, separating people as far as practical, and testing extensively)”*. This is the day before Mr Drakeford states in the Senedd (for the second time) that there was no clinical value in routine testing.

g. 7 May 2020 SAGE 34 - §§1 and 14 “SAGE reiterated its advice that there should be extensive testing of healthcare workers including asymptomatic workers” and SAGE reiterated the importance of addressing the epidemic in the healthcare and care home sectors and reiterated its advice that there should be extensive testing of healthcare workers including asymptomatic workers as well as the application of other measures previously advised. SAGE participants offered to provide advice to the healthcare worker testing programme if required.

52. During the Module 7 hearings, the Welsh Government maintained that they did not delay the introduction of asymptomatic testing in care homes and that they responded promptly to the ‘new’ advice of SAGE on 12 May 2020. However, the evidence exposes this for what it is: an after the event corporate position statement that seeks to avoid criticism for delaying testing rather than a factually accurate account of what happened that would provide much needed answers for the families of the bereaved.
53. CBFJ Cymru believes that the most likely explanations for the failure of the Welsh Government to introduce routine testing sooner are because of a lack of testing capacity and concerns that such testing would require large numbers of staff to isolate leading to staff shortages (for both of which the Welsh Government bore responsibility). Blaming scientific uncertainty was a convenient means of avoiding this responsibility.
54. In the final analysis, and for reasons still yet to be fully explained, Wales was slow to acknowledge the risks of asymptomatic transmission and the value of asymptomatic testing. Whatever the reason, the delay undoubtedly calls into question the view expressed by Mr Drakeford in oral evidence that in Wales:

we planned first and then we announced. And sometimes that makes us look like we were doing things later than was happening elsewhere, but I believe that our method was more effective [6/208/9-13].

55. What was more effective, the CBFJ Cymru asks, about repeated delays in the implementation of essential safety measures which endangered the lives of so many of the most vulnerable people in Wales? Further, the Welsh Government was not planning how to implement routine testing in care homes before making that announcement in May 2020; it was denying that there was a clinical value to it at all.
56. The CBFJ Cymru made reference in its opening to the question posed by CTI in Module 2B, namely whether the Welsh Government’s position on asymptomatic testing was a

position that could have been genuinely or sensibly held. And the CBFJ Cymru suggest that it is abundantly clear from the evidence that it was neither

(2) Delays and failures in testing regime for priority testing groups

57. On 24 April 2020, the Welsh Government published its Covid 19 exit strategy: 'Leading Wales out of the coronavirus pandemic: a framework for recovery' [INQ000083221]. The strategy indicated that in order to understand the level of infection in Wales, the Welsh Government was stepping up its testing capacity and capability. However, the strategy contained no detail on how such testing capacity and capability would be accelerated. When asked about these deficiencies in the Senedd on 29 April 2020, Mr Drakeford reiterated Wales' focus on testing only key workers. And, in the same session, he added that to draw "*any value from testing non-symptomatic people, you'd have to do it every day*", which would "*take away*" tests from others that need the testing. Despite all the evidence given in Module 7, the reason for the Welsh Government's reluctance to test and their lack of focus on testing remains unclear.
58. The deficiencies of the Covid 19 exit policy underpinned wholly inadequate and delayed testing decisions, the most notable of which are as follows:
- a. The failure to test hospital patients upon discharge to care homes
 - b. Delays to routine testing within care homes
 - c. Delays to/insufficient routine testing among health care workers
 - d. Delays to/insufficient routine testing of patients in hospital

a. The failure to test hospital patients upon discharge to care homes

59. Over 1,000 patients were discharged from hospital into care homes in Wales, prior to the introduction of testing on discharge on 29 April 2020. This practice seeded infections into vulnerable communities, and was exacerbated by the lack of PPE, testing, and effective treatment and equipment available in care homes. It continued notwithstanding concerns as to the vulnerability of care home residents raised in the Senedd on 3 March 2020 [INQ000321248] and reiterated by Care Inspectorate Wales on 8 April 2020 [INQ000198288 and INQ000396510].
60. Despite these concerns, and knowing the risks of asymptomatic transmission, the Welsh Government refused to introduce testing on discharge to care homes on 8 April 2020 because of insufficient testing capacity [INQ000551798_0089]. CBFJ Cymru disputes the legitimacy of this justification because the number of untested discharges to care

homes per day in Wales at this time was just 10.5 [INQ000271757_0008] and while testing capacity was not large (1000 tests per day as at 9 April rising to 1800 by 20 April [INQ000312371_0002 and INQ000253584]) there was sufficient from which to prioritise this small number of discharges having regard to the serious danger of asymptomatic introduction of Covid-19 into a vulnerable care home community.

61. Further, the introduction of testing on discharge in Wales was some two weeks after testing on discharge was introduced in England (on 16 April 2020), and this same delayed and reactionary process is repeated throughout the pandemic.
62. The Welsh Government issued an apology in its opening submissions in Module 7: *“there ought not to have been a delay between the 15 April 2020, when the risk came to the fore...and the ultimate publication of guidance on 29 April 2020”* [1/124/7-11]. However, no explanation for the delay has been provided.
63. Incredibly, this practice of transferring Covid-19 positive patients into care homes persisted into wave 2 in Wales, with patients judged to be ‘non-infectious’ being discharged from hospital without a negative test from December 2020 [INQ000262400]. While recommending the change in policy, the TAG statement acknowledged that *“there remains uncertainty around the period of infectivity for individuals infected with SARS-CoV-2”* [INQ000227902_0004]. Concerns about this policy were raised with Welsh Government via email by the Older People’s Commissioner for Wales, who wrote that *“this indicates that some risk would remain that individuals could still be infectious in this situation and could post a risk of an infection spreading in a care home or other setting”* [INQ000185049_0001].
64. This change in policy was implemented at a time when the number of deaths involving Covid-19 in care homes was increasing - notifications to CIW of deaths in adult care homes increased from 21 in October 2020, to 217 in December 2020, and nearly doubled in January 2021 to 417 [Module 6 - INQ000198645]. Given the huge increase in deaths in care homes during wave 1, this decision demonstrates reckless disregard to learn lessons, to recognise the risks for vulnerable care home residents, and to avoid the huge loss of life experienced in the second wave.

b. Delays to routine testing within care homes

65. The failure of the Welsh Government to provide routine testing in care homes is a matter of very great concern for the CBFJ Cymru and encapsulates everything that was

wrong about the approach of the Welsh Government to the pandemic, including a failure to take a precautionary approach to the risks of asymptomatic and aerosol transmission; inaccurate claims that testing had no value; numerous changes of policy; a lack of transparency; and delays in implementation, including in comparison with other UK countries.

66. Over this period, a member of the CBFJ Cymru, who owned and ran a care home in Wales, campaigned extensively for routine testing because of the risks of asymptomatic transmission. It was glaringly obvious to her as someone working on the front line that routine testing was essential. As elderly and vulnerable care home residents were falling ill and dying within 48 hours of becoming symptomatic, she pressed for further testing. PHW, who were supposed to provide the test, were often unable to provide testing quickly enough in the period between the onset of symptoms and death [INQ000587321_0010]. Her increasingly desperate messages to the Welsh Government in April and May 2020, included the warning:

I do not know how long it is going to be before relatives of the deceased speak to one another and realise they are not going to be treated with the same importance as England (less than 9 miles from here)...Relatives are assuming these tests are being carried out as they see it on their national news...and [would] be horrified to learn that the Welsh Government has decided it [i.e. testing] is not important enough [Module 6 - INQ000598470_0002].

67. On 16 May 2020 the Welsh Government announced routine testing in care homes. No satisfactory explanation has been provided for why it took until 16 May 2020 to announce routine testing for residents of large care homes, and why it took until 15 to announce routine testing of residents in care homes of all sizes, as well as care home workers (as stated above the risks and grave consequences of not doing so were known from at least 3 April 2020).
68. Lack of testing capacity is an unsatisfactory explanation: it points to a chronic failure to plan and an inability to scale up effectively. It also leaves unexplained the consistent under-use of testing capacity in Wales throughout April, May and June 2020, as set out in the table below:

Date	Testing capacity ²	Actual usage	Percentage	Reference
09.04.2020	1,000	1,254	125%	INQ000312371_002
20.04.2020	1,800	1,033	57%	INQ000253584
05.05.2020	2,100	743	35%	INQ000530780
02.06.2020	9,500	2,400	25%	INQ000087992_012

69. Various explanations have been advanced to explain under-use of tests in Wales. The Welsh Government sought to suggest that under-use was a necessary feature of the system: *“you can’t run the [testing] system at full throttle every single day”* [6/182/10-11]. A further explanation was that some tests needed to be held back for *“some emergency in the Covid context where you will need some spare tests”* [6/182/7-8]. Finally, it was suggested that it was necessary to set aside some tests for non-Covid matters [6/182/18-19].
70. These ineffectual explanations do not properly justify why it was that in early May 2020, when infections and deaths from Covid-19 were at a peak, 65% of PHW testing capacity in Wales was left unutilised. To suggest that keeping tests for ‘some emergency’ or ‘non-Covid’ matter should take precedence over the lives of vulnerable care home residents is derisory and an affront to the many members of CBFJ Cymru whose family members died in Welsh care homes during this time.
71. It reveals a complete failure to take a precautionary approach to protecting the lives of older people in Wales. Mr Drakeford told the Inquiry he believed that the Welsh Government *“did take a precautionary approach. And then the question is: could we have taken a more precautionary approach? And I don’t think the evidence would have justified us in doing so”* [6/203/15-18]. The CBFJ Cymru disagree and submit that there is ample evidence before the Inquiry that routine testing of all staff and residents within care homes should have become Welsh Government policy much sooner.

c. Delays to/insufficient routine testing of healthcare workers

72. Experts recognised early on that routine testing of healthcare workers was, to quote Sir Paul Nurse, *“absolutely clear that was essential”* [4/40/25]. It would help prevent nosocomial infection and would maintain, rather than deplete, workforce levels. The

² Refers to daily testing capacity within PHW laboratories and in due course the Welsh share of testing capacity within Lighthouse Laboratories.

Inquiry heard similar evidence from Professor Kloer in Module 3: testing limited viral spread [Module 3 – INQ000475209_0005, §33].

73. In Wales, routine testing of healthcare workers was not announced until 4 December 2020 (following the usual pattern of two to three weeks after England, which announced on 16 November 2020). However, many Health Boards in Wales did not implement routine testing of healthcare workers until March 2021. Some were even later: Hywel Dda University Health Board took a phased approach to routine testing which commenced in February and was completed by July 2021 (albeit the majority of staff were tested by the end of March 2021) [Professor Kloer; Module 3 30/162/12-164/18]. Furthermore, whilst the policy mandated testing twice weekly, testing took place every five days.
74. Of course, lateral flow tests only became widely available in November 2020, but that does not explain (i) why greater use of existing capacity was not used to test before 14 December 2020, and (ii) more importantly, why even when lateral tests were available, routine testing took until March 2021 to implement, after wave two. Mr Gething told the Inquiry he *“was pretty frustrated at the lack of pace in the use of the tests”* [6/161/12-13]. He went on to say:

...having a phased rollout through areas is fine, but for it to take that long, isn't fine...when I make a ministerial choice, I expect the system to deliver on that choice...if it's not happening, then I can't do anything about it if I don't know, and I don't think Welsh Government officials were really properly sighted on it... [6/162/14-23].

75. At no stage, did Mr Gething offer any explanation as to why it took until March 2021 for the routine testing of healthcare workers to be implemented, preferring instead to attribute delays to the local health boards. Nor did he accept any responsibility for the complete breakdown in implementing Welsh Government policy decisions, or the related communication failures between Welsh Government and other public bodies.

d. Delays to/insufficient routine testing of patients in hospital

76. The Welsh Government announced testing of all patients on admission to hospitals on 3 June 2020 and again on 15 July 2020. Reminders had to be sent out to NHS Wales directors in September 2020 because the policy was not being implemented properly. And it was not until 28 January 2021 that the Welsh Government introduced repeat testing of patients every five days.

77. But problems in testing and repeat testing endured, notwithstanding reminders and notwithstanding new policies. The Audit Wales report of March 2021, 'Test, Trace and Protect, an overview of progress to date' reported:

1.18 PHW figures show that compared to the first wave of the pandemic, hospitals have been testing proportionately more patients on admission, increasing from 24% in the first wave to 54% in October, but there remains considerable room for improvement...Once tested on admission however there has been no regular testing during a patient's hospital stay unless patients have developed symptoms...

1.19 ...It has been clear that once an in-hospital outbreak occurs, spread of COVID-19 as a result of hospital transmission has...resulted in very poor outcomes for patients... [INQ000214244_0017].

78. The report concluded that nosocomial infections could have been reduced by more effective testing, including more frequent testing during a patient's stay. This much known is by the CBFJ Cymru as many of their loved ones fell victim to basic testing failures. More frustratingly, witnesses offered no explanation for such failures. Along with the failure in routine testing of healthcare workers, blame was simply laid at the door of the health boards.
79. There has been no attempt to explain why this was so. And of course, without insights or reflections, there is no hope for lessons learned.
80. In Wales, routine testing was introduced on admission with five days repeat testing for asymptomatic patients from 28 January 2021 [INQ000227387]. This was in contrast to the approach in England where repeat testing was every three days. However, many patients were not tested in accordance with that policy, waiting many more days for repeat testing. Some reported loved ones being sent home following an outbreak in the ward, in order that the ward could be cleaned, but without being tested; they died in their homes.
81. The experiences of the families provide valuable context for such policies. Their experiences demonstrate clearly the chaotic testing in hospitals throughout the pandemic:
- a. October 2020: Anna-Louise Marsh-Rees, co-leader of the CBFJ Cymru, recalls how her father was admitted to hospital for a routine operation and was tested for Covid on admittance. He was negative. He was moved six times in eight days, ending up in a ward in which 21 patients and 13 staff had Covid. He was

discharged without being tested again (hospital staff told him they only tested those being discharged to care homes). Neither he nor any of his family members were advised to take a test. He deteriorated immediately once home and had to be re-admitted to hospital one week later. He was tested on admittance and tested positive for Covid-19. Tragically, he died three days later.

- b. December 2020: another member recalls how her loved one was admitted to hospital in December 2020 (with a non-Covid related issue) and his health rapidly deteriorated. However, he was not tested for Covid until his fourth day following admission. Instead, he underwent a series of intrusive and invasive tests during that period before being tested for Covid, which returned as positive. He was discharged, without a further test, and died.
- c. December 2020-January 2021: Jane recalls how the GP told her he suspected both her parents had Covid. Her father went to hospital first, was tested on admittance and the test was positive. He was admitted to a corridor, before being moved to a cubicle. Tragically he died. Jane's mother went to hospital a few days later. She had a test on admittance and the test was negative. Jane was told her mother was fit for discharge and could be collected. Jane insisted she have three clear tests before she returned home. A few days later, she had a second test, which was positive, and she was admitted to a Covid ward. However, in the intervening period, she was permitted to wander freely in the (non-Covid) wards, without a mask, interacting with patients and no doubt (completely unknowingly) contributing to the spread of the infection within the hospital.
- d. February 2021: Theresa (who appeared on the 'Impact' video in Module 1) recalls how her mother was admitted to hospital for a non-Covid related matter. She was tested whilst in her ward, and the test result was negative. She was not tested until 10 days later, despite the policy to test every five days, and despite the ward (with patients in it) being closed due to a Covid outbreak. Her second test was positive. Tragically, she died a few days later having tested positive for Covid.

(3) Restricting access to testing to 'the cardinal three'

- 82. The CBFJ Cymru is also aware that testing criteria in Wales was limited to the three cardinal symptoms – fever, continuous cough and loss of smell. However, many people experienced a wider range of symptoms, such as headaches, sore throat, fatigue, nausea, diarrhoea etc. The Welsh Government's failure to acknowledge this broader range of symptoms in testing criteria, even as late as March 2021, would have led to countless instances of symptomatic people continuing to spread the virus. Exhibited to

the Module 3 witness statement of the CBFJ Cymru's co-lead, Anna-Louise Marsh-Rees, is a letter that her father (as a Shielding Patient) received from the CMO for Wales, Sir Frank Atherton, in October 2020 that states:

You will need to self-isolate if you develop one of the following symptoms, a new continuous cough, a high temperature, loss of or change to sense of smell or taste. You should also apply for a test online if you develop one of these symptoms.
[INQ000327639_0005]

83. Dr Howe acknowledged the possibility that this decision meant that people with the virus remained untested [9/117/4-9].
84. Like so many aspects of the testing regime, the decision making here demonstrates the very opposite of a precautionary approach in action. The Inquiry has heard from Professor Tim Spector that as early as March 2020, he and his colleagues had evidence that "*in the elderly aged over 75, acute confusion could be the only presenting symptom*" [INQ000575990_0004, §8].
85. Yet, despite Ministerial Advice dated 23 March 2021 that the "*current 3 cardinal symptoms together have a combined specificity of approximately 50%*" and that symptom criteria for public **access** to a test should be broadened [INQ000116616_0012-0013], the recommendation to the Minister was that "*national messaging should remain focussed on the 3 primary symptoms*" [INQ000116616_0001]. Undoubtedly this resulted in healthcare workers and patients, and care home workers and residents, experiencing symptoms but not realising that they should be tested and inadvertently transmitting the virus.

(4) Failure to meet testing targets

86. The ability to set clear targets for testing is plainly an important feature of any effective policy. However, the CBFJ Cymru are concerned at what appears to be a lack of communication between the Welsh Government and PHW regarding testing targets in Wales. The Minister for Health and Social Services, Vaughan Gething, had communicated in March 2020 the target of increasing capacity to 9,000 daily tests in Wales by the end of April 2020. However, when questioned by the Senedd Health and Social Care Committee in May 2020, Dr Tracey Cooper (the Chief Executive of PHW) insisted that this was not a target she was familiar with. The CBFJ Cymru question how

this can be the case, when PHW had briefed Mr Gething on 20 March 2020 of this capacity target of 9,000 tests [INQ000195536].

B. Tracing

87. The tracing programme was inadequate in Wales. It completely overlooked care homes, and there was no attempt to trace anyone that had been in contact with an infected patient or healthcare worker during a cluster outbreak. The proximity app, introduced presumably because of its anticipated value, had very low take-up levels.
88. A key concern held by the CBFJ Cymru is that contact tracing in Wales was halted in March 2020 and did not restart until June 2020, almost two months after the peak of the first wave in Wales on 12 April 2020.
89. In relation to paper-based tracing, restaurants and the hospitality industry in Wales regularly required customers to complete paper-based forms for the purposes of contact tracing, and the CBFJ Cymru wished to understand if this largely paper-based data was provided to, and used by, the Welsh Government or PHW in the tracing programme, and if so, how this data was shared and used. The CBFJ Cymru sought clarity on the voluntary nature of such systems and is concerned that the inefficiency and ineffectiveness of such schemes allowed the virus to spread further and contribute to the overwhelming second wave of Covid-19 in Wales.
90. In relation to the NHSX 'app', the CBFJ Cymru wished to know how this was used in Wales, how many people in Wales used the app, how the data was used and what procedures were in place following a close contact alert. In particular, the CBFJ Cymru raised three issues relating to NHSX that were of particular concern:
 - a. what consideration was given to the population in Wales who did not have smart phones or may have had challenges due to technological literacy, and limited internet access, such as with the older population and those living in rural areas?
 - b. why was the NHSX unfit for purpose in the healthcare setting? The CBFJ Cymru understands healthcare workers were notified when there was a Covid patient nearby, even if separated by a wall. Such features meant healthcare workers turned off the NHSX app. This would have defeated the purpose of contact tracing within the app, and would have put many lives at risk, particularly vulnerable people in healthcare settings.

- c. why was there a significantly lower uptake of the app in Wales than in England, as demonstrated by the map prepared by Professor Fraser [INQ000475153_0027, §74 (figure 1b)].

91. Despite three weeks of evidence, these important questions in relation to Wales remain unanswered.

Conclusion – the Whole System

92. In connection with an initial report by Independent SAGE in early May 2020 on ‘how can testing and tracing be successfully achieved’, Professor McKee asked, “*Can we take a whole systems approach to understanding tracking and tracing?*” [2/52/20-21]. Professor Fraser told the Inquiry, “[t]he whole system is important” [2/203/18] and Professor Buchan’s evidence was:

...testing is more than a test. It is a whole system. It is a system embedded in a community that requires tracing around people who test positive, the understanding of why that tracing is important, effective means of isolation, including support for people in isolation, to consider social and economic factors. That is, it’s a whole-community, whole-system approach [3/6/1-8].

93. This view was shared by SAGE as seen in the minutes from SAGE 53 on 27 August 2020:

The effectiveness of mass testing will depend on several factors including the proportion of the population tested; the frequency of testing; the ability of a test to identify true positives and negatives; the speed of results; and adherence to isolation. It is important to recognise that testing is one part of a system leading to isolation of infectious individuals and the whole system needs to work in order to achieve the desired aim (which would be to identify as many infectious people as possible and isolate them from contacts during the infectious period) [INQ000061561_0003, §18].

94. The CBFJ Cymru support these views. There is a crucial need for a system that is comprehensive, mutually reinforcing, and capable of being implemented quickly when needed – not one that takes months to establish while infections rage, putting lives at unnecessary risk.



SURGICAL MATERIAL TESTING LABORATORY

TEST REPORT

Testing of 3M FFP3 respirators

Report No: 20/6058/1

Report Date: Thursday 27th February, 2020

Authors:
Louise Barry

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SMTL
Princess of Wales Hospital
Coity Road
Bridgend
CF31 1RQ

Web: www.smtl.co.uk
Email: info@smtl.co.uk
Tel: 01656 752820
Fax: 01656 752830

Testing of 3M FFP3 respirators

Report No: 20/6058/1

Louise Barry

Thursday 27th February, 2020

1 Name & Address of Client/Requesting Authority

Procurement Services,
NHS Wales Shared Services Partnership,
4th Floor,
Companies House,
Crown Way,
Cardiff, CF14 3UB.

2 Introduction

SMTL were requested by NHS Wales Shared Services Partnership - Procurement Services to test samples of 3M FFP3 respirator masks which were past their expiry date. The testing was based on testing undertaken in 2009 for similarly expired masks.

For comparison purposes, laboratory physical testing was also performed on masks currently available from Welsh Procurement stores. These masks were within their shelf life date but are of a different design to the expired stock samples.

3 Test Products/Samples for this project

Table 1: Samples

Manufacturer	Product Name	Description	Catalogue Number	Batch/Lot Number	Quantity	Date received	SMTL Sample ID
3M	Particulate Respirator	EN 149:2009 FFP3 R D	8833	725908	80	31/01/2020	62386
3M	Health Care Respirator	EN 149:2001 FFP3	1873V	NOT SUPPLIED	90	31/01/2020	62387
3M	Health Care Respirator	EN 149:2001 +A1:2009 FFP3 R D	1895V+	M1C192970241	20	04/02/2020	62389
3M	Aura Health Care Respirator	EN 149:2001 +A1:2009 FFP3 NR D	1863+	C191501	20	04/02/2020	62390
3M	Aura Health Care Respirator	EN 149:2001 +A1:2009 FFP3 NR D	9332+	C193241	20	04/02/2020	62391

NOTE:

- The test results in this report relate only to the test sample(s) analysed.
- The Manufacturer, Product Name, Description, Catalogue & Batch Numbers were provided by the client.

Images of the two expired masks can be seen in Figures 1 and 2.



Figure 1: Mask model: 1873V



Figure 2: Mask model: 8833

3.1 Departures/Abnormalities of Sample Condition

- SID 62386 had an expiry date of 13/10/2016
- SID 62387 had an expiry date of 01/08/2019

4 Date of Testing

3rd - 12th February 2020

5 Location of Testing

- EN 143 NaCl filter penetration testing was subcontracted to and performed at S.F.P. Services Ltd., Unit 12, Sea Vixen Ind. Est., Wilverly Rd., Christchurch, BH23 3RU.
- All other testing was performed at SMTL premises.

6 Testing Details

6.1 Filtration Efficiency (FE)

EN 149:2001^[1] (the European Standard for respiratory protective devices) classifies masks as FFP1, FFP2 and FFP3 depending on their filtration efficiency. Two FE tests are specified in the standard - one for sodium chloride penetration, the other for paraffin oil. EN 143:2000^[2] defines the test method used in EN 149:2001^[1].

In 2009, SMTL discussed the most appropriate test programme with 3M, the HSE and Dr Tony Wilkes (Dept. of Anaesthetic Maintenance, UHW). It was agreed that the paraffin oil test was less relevant to the NHS requirements, and that the NaCl test would be sufficient to assess whether the filter media still performed to specification.

6.2 Face-Fit testing

The HSE also stated (in 2009), in a telephone conversation, that in their view some form of fit testing was necessary to demonstrate that the mask seal, straps and filter medium were performing adequately, and mentioned RPA (Respiratory Protective Assessment) as a possible provider of the test. RPA undertook the testing in 2009, and therefore SMTL contacted RPA again for this project in 2020.

RPA confirmed that they were able to perform fit testing on healthy volunteers at SMTL using both 8833 and 1873V masks using a twin channel particle counter which measures ambient particulate levels in the room and inside the mask, and calculates an arbitrary 'Fit Factor' level based on the reduction in particle counts inside the mask.

The test machine used is a TSI Portacount. The test method is a quantitative method (as opposed to the qualitative methods used with taste detection). Ten SMTL staff volunteered to take part in this test but one member of staff was unable to complete the test.

During the test, the user wears the mask which is monitored continuously, and performs a series of exercises as recommended by the HSE in monograph 81 of HSE 282/28^[3], which includes periods of normal breathing, deep breathing, head turning, speaking and bending from the waist.

The aim of this exercise was to compare mask performance on individuals whom the mask fitted as opposed to assessing the individual volunteer's goodness of fit.

6.3 Physical testing of component parts

The final set of tests were designed to check if the physical properties of component parts of the mask such as the elastic straps and the foam seal were comparable to similar "in date" masks.

6.3.1 Force at Break of the straps

Using an Instron Tensometer, Force at Break (FAB) tests were performed on samples of straps from the masks using a 100mm gauge length and a cross-head speed of 500mm/min.

6.3.2 Force at Break of the foam

Using an Instron Tensometer, Force at Break (FAB) tests were performed on cut dumbbells of foam from the masks using a gauge length of 40mm and a cross-head speed of 500mm/min.

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6.3.3 Elasticity

Using an Instron tensometer, the force at 50% extension was measured on samples of straps from the masks using a gauge length of 100mm and a cross-head speed of 500mm/min.

6.4 Standards relevant to the test method

- BS EN 143:2000 - Respiratory protective devices. Particle filters. Requirements, testing, marking^[2].
- BS EN 149:2001 - Respiratory protective devices. Filtering half masks to protect against particles. Requirements, testing, marking^[1].
- HSE OC 282/28 - Fit testing of respiratory protective equipment facepieces^[3].

6.5 Testing Conditions

No special conditions required

6.6 Deviations/exclusions from, and additions to standard methods

None.

6.7 Sampling Details

All samples were selected and supplied by the client.

6.8 Sample Preparation

As per the sub-contractors requirements or the relevant SMTL Test Method.

7 Results

7.1 Filtration Efficiency

The results of the Sodium Chloride testing for the two mask types are presented in Tables 2 and 3 respectively. EN 149 requires FFP3 masks to show a penetration level of $\leq 1\%$. As can be seen from Tables 2 and 3 both masks exceeded this performance requirement.

Table 2: Results of Sodium Chloride Efficiency 8833 (SID 62386)

Sample No	Penetration NaCl (%)
1	0.081
2	0.32
3	0.175
4	0.231
5	0.049
6	0.119
7	0.012
8	0.049
9	0.088
10	0.112
Mean	0.124
Std. Dev.	0.09

Table 3: Results of Sodium Chloride Efficiency 1873V (SID 62387)

Sample No	Penetration NaCl (%)
1	0.018
2	0.027
3	0.028
4	0.023
5	0.023
6	0.039
7	0.247
8	0.029
9	0.032
10	0.024
Mean	0.049
Std. Dev.	0.07

7.2 Face-Fit Testing

The Portacount test kit results give a 'Fit Factor' as described in HSE 282/28, and FFP3 half masks are required to show fit factors of ≥ 100 . The results of the testing are presented in Table 4.

Table 4: Results of Face-Fit Testing

ID No	Model No.	Fit Factor	Pass/Fail
11/11/74	8833	0	FAIL
11/11/74	1873V	177	PASS
12/11/87	8833	0	FAIL
12/11/87	1873V	0	FAIL
15/09/91	8833	2739	PASS
15/09/91	1873V	0	FAIL
07/03/74	8833	2030	PASS
07/03/74	1873V	0	FAIL
26/10/83	8833	3811	PASS
26/10/83	1873V	0	FAIL
11/13/82	8833	0	FAIL
11/13/82	1873V	0	FAIL
22/08/95	8833	4843	PASS
22/08/95	1873V	221	PASS
18/03/60	8833	2854	PASS
18/03/60	1873V	794	PASS
09/04/62	8833	1788	PASS
09/04/62	1873V	0	FAIL

- Model number 8833 is SID 62836
- Model number 1873V is SID 62837
- Two of the test subjects had pass results for both masks.
- Mask 8833 had six passes.
- Mask 1873V had three passes.
- Where users failed to achieve a pass on the test, it was possible to achieve a pass result after testing was complete by holding the mask in place on the face of the test subjects. These results are not documented in the table above.

7.3 Physical Testing

The results tables below give test data both from masks which are past their expiry date and which are within their expiry date. Tables related to masks which are past their expiry date include the expiration information in the table caption.

The samples which were tested for physical properties, including their expiry date, are listed in Table 5:

Table 5: List of samples undergoing physical testing

Cat No.	Sample ID	Expiry Date
8833	62386	13/10/2016
1873V	62387	01/08/2019
1895V+	62389	27/10/2024
1863+	62390	30/05/2024
9332+	62391	20/11/2024

7.3.1 Force at Break - Straps

The force at break testing for the elastic straps of the masks are presented in Tables 6 - 10.

Table 6: Results of Force At Break Testing - Straps 8833 (SID 62386) - expired 13/10/2016

Sample No	Force At Break (N)
1	109.07
2	109.81
3	104.46
4	103.00
5	104.66
Mean	106.20
Std. Dev.	3.0

Table 7: Results of Force At Break Testing - Straps 1873V (SID 62387) - expired 01/08/2019

Sample No	Force At Break (N)
1	15.24
2	15.17
3	14.74
4	15.48
5	14.39
Mean	15.00
Std. Dev.	0.4

Table 8: Results of Force At Break Testing - Straps 1895V+ (SID 62389)

Sample No	Force At Break (N)
1	394.40
2	406.12
3	400.82
4	406.93
5	412.86
Mean	404.23
Std. Dev.	7.0

Table 9: Results of Force At Break Testing - Straps 1863+ (SID 62390)

Sample No	Force At Break (N)
1	17.46
2	14.42
3	14.65
4	14.05
5	12.99
Mean	14.71
Std. Dev.	1.7

Table 10: Results of Force At Break Testing - Straps 9332+ (SID 62391)

Sample No	Force At Break (N)
1	17.19
2	16.83
3	16.09
4	17.05
5	16.00
Mean	16.63
Std. Dev.	0.6

7.3.2 Force at Break - Foam

Due to the size of the foam on the masks it was only possible to test model 8833. The results of this testing are presented in Table 11.

Table 11: Results of Force At Break Testing - Foam 8833 (SID 62386) - expired 13/10/2016

Sample No	Force At Break (N)
1	5.04
2	4.81
3	4.21
4	4.68
5	4.27
Mean	4.60
Std. Dev.	0.4

7.3.3 Force at 50% extension - straps

The results of the force required to achieve 50% extension testing are presented in Tables 12 - 16.

Table 12: Results of Force At 50% Extension Testing - Straps 8833 (SID 62386) - expired 13/10/2016

Sample No	Force At Extension (N)
1	2.51
2	2.60
3	2.70
4	2.64
5	2.56
Mean	2.60
Std. Dev.	0.1

Table 13: Results of Force At 50% Extension Testing - Straps 1873V (SID 62387) - expired 01/08/2019

Sample No	Force At Extension (N)
1	1.46
2	1.42
3	1.42
4	1.41
5	1.53
Mean	1.45
Std. Dev.	0.0

Table 14: Results of Force At 50% Extension Testing - Straps 1895V+ (SID 62389)

Sample No	Force At Extension (N)
1	5.91
2	5.43
3	5.25
4	5.48
5	5.56
Mean	5.53
Std. Dev.	0.2

Table 15: Results of Force At 50% Extension Testing - Straps 1863+ (SID 62390)

Sample No	Force At Extension (N)
1	1.69
2	1.92
3	1.96
4	1.91
5	1.65
Mean	1.83
Std. Dev.	0.1

Table 16: Results of Force At 50% Extension Testing - Straps 9332+ (SID 62391)

Sample No	Force At Break (N)
1	1.70
2	1.78
3	1.40
4	1.73
5	1.67
Mean	1.66
Std. Dev.	0.1

8 Discussion

8.1 Fit Test results

The masks tested were available in a single size and were not easily adjustable. During testing, the tester from RPA observed that for some members of staff, especially female staff, the mask was too big for their face and did not fit well. It is therefore unsurprising that these subjects failed the fit test.

Although not documented, it was the opinion of the accredited RPA tester that the masks passed the testing when fitted to appropriately sized volunteers. Where the masks fitted a member of staff correctly, the results of both mask designs were very good, although the 1873V mask usually underperformed the 8833 mask.

Our opinion is that the failures of the masks were probably due to the sizing of the mask rather than the performance of the mask.

8.2 Physical test results

As the mask models are different from those tested in 2009, (out of date versus in-date testing of Cat 8835) and also from in-date stock from stores, the conclusions we can draw from the physical testing is necessarily limited.

8.2.1 Foam

For the foam testing, we have historical data from the masks tested in 2009 (Cat 8835) and current data from the Cat 8833 expired mask. The mean FAB results are:

- 8833 (expired) - 4.6N
- 8835 (from 2009) - 5.1N

Although it is unknown if we are comparing identical foams, the difference between the two products is approximately 10%. If we assume that the foams were identical in the first place, our opinion is that whilst these results may indicate minor loss of tensile strength of the foam, a variation of 10% in physical properties in elastic products is not unusual in our experience. On balance we do not think that the foam has degraded substantially

8.2.2 Head straps

Mask models 1873V (expired), 1863+ and 9332+ all use a head-strap which is similar to a rubber band. Our opinion is that this is more likely to degrade over time compared to the elastic straps used on 8833 and 1895V.

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The mean Force at Break (FAB) for the 'rubber band' style head straps are:

- 1873V (expired) - 15.0N
- 1863+ (in date) - 14.7N
- 9332+ (in date) - 16.6N

As the expired stock 1873V has a very similar FAB profile to the similar in-date stock, our opinion is that there is no evidence that the head strap on the expired product has degraded noticeably compared to the in-date product.

The Force at 50% extension for the 'rubber band' style head straps are:

- 1873V (expired) - 1.45N
- 1863+ (in date) - 1.83N
- 9332+ (in date) - 1.66N

Again, although it is unknown if we are comparing identical straps, the difference between the expired product and the two in-date products is approximately 20% for the 1863+ and 10% for the 9332+.

Similarly to the foam, our opinion is that whilst these results demonstrate differences between the expired masks and the in-date masks, the in-date masks have a 10% difference between them, and a variation of 10% in the physical properties in elastic products is not unusual in our experience.

On balance we do not think that the elastic band style straps have degraded substantially

The straps on the 8833 mask and the 1895V+ mask are substantially different and we cannot comment on the differences between the results. It is, however, worth noting that the FAB and Force at 50% extension is much higher for the 8833 expired mask than the rubber band style in-date masks.

8.3 Summary

The results above show that:

1. The filter material has been shown to pass the performance requirement for both expired masks;
2. The fit tests demonstrate that both expired masks can pass the performance requirement if it is the appropriate size for the member of staff and fits well;
3. There was no visible degradation of the mask materials (mask, head strap and foam where used);
4. The physical tests (FAB and extension tests) do not show significant variation from similar in-date product.

Therefore it seems reasonable to conclude that if a member of staff has been successfully fit-tested with the same model of mask previously then these masks should perform appropriately on that subject.

9 Authorisation

Approved and signed electronically. Please see last page of this document.

Pete Phillips, Director, SMTL.

References

- [1] CEN. *BS EN 149:2001 - Respiratory protective devices. Filtering half masks to protect against particles. Requirements, testing, marking.*
- [2] CEN. *BS EN 143:2000 - Respiratory protective devices. Particle filters. Requirements, testing, marking.*
- [3] HSE. *Fit testing of respiratory protective equipment facepieces.* [OC 282/28].



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Pete Phillips, Director SMTL
2020.02.27 16:27:35 GMT
SMTL, Bridgend, UK.

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