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

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

SUBMISSIONS ON BEHALF OF
COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU
FOR THE PRELIMINARY HEARING FOR MODULE 3
ON 10 APRIL 2024

Introduction

1. Submissions are made on behalf of Covid-19 Bereaved Families for Justice Cymru (CBFJ Cymru) with reference to the following agenda headings:

    a. Rule 9;
    b. Spotlight Hospitals;
    c. Impact Evidence;
    d. Disclosure;
    e. Expert Evidence.

2. In preparing these submissions, CBFJ Cymru has had particular regard to 'Module 3: Counsel to the Inquiry's Note for the Third Preliminary Hearing on 10 April 2024' dated 13 March 2024 ('Counsel to the Inquiry's Note') and proposed Agenda.

Rule 9

3. CBFJ Cymru is grateful for the monthly updates in respect of the Rule 9 requests together with the update set out at paragraphs 3 to 14 of Counsel to the Inquiry's Note.

4. Within its submission for the last preliminary hearing on 27 September 2023, CBFJ Cymru stressed the importance of obtaining Rule 9 statements from i) organisations and

institutions whose members work within the healthcare sector in Wales; ii) the Welsh divisions of the Royal Colleges; and iii) charities, groups and non-governmental organisations operating in Wales. CBFJ Cymru provided 24 suggestions of relevant individuals/organisations to be approached. CBFJ Cymru understands from the monthly updates that Rule 9 requests have been sent to some but not all of these individuals/organisations to date. CBFJ Cymru repeats its request for Rule 9 requests to be sent to the following outstanding organisations/individuals and, if required, can provide further information to the Inquiry as to the justification for each of these requests:

a. NHS Wales;
b. Aneurin Bevan University Health Board
c. Betsi Cadwaladr University Health Board
d. Cardiff and Vale University Health Board
e. Cwm Taf Morgannwg University Health Board
f. Hywel Dda University Health Board
g. Powys Teaching Health Board
h. Swansea Bay University Health Board
i. Digital Health and Care Wales
j. Health Inspectorate Wales ('HIW')
k. Care Inspectorate Wales ('CIW')
l. Office for National Statistics
m. Professor Steve Martin, Director of Wales Centre for Public Policy
n. Professor Adrian Edwards, Director of Wales Covid-19 Evidence Centre
o. Professor Mark Taubert, Chair of Advance & Future Care Planning Group including their DNACPR policy

5. CBFJ Cymru is grateful that the Inquiry team is adopting a proactive and robust approach to Rule 9s and is reassured that the Inquiry is utilising the tools in its arsenal including the issuing of Section 21 Inquiries Act 2005 Notices.

6. CBFJ Cymru notes that Section 21 Inquiries Act 2005 Notices ('Section 21 Notice') have been sent to various organisations to include the Welsh Government Health and Social Services Group. Within its written submission for the last Preliminary Hearing dated 27 September 2023, the Welsh Government stated its commitment to co-operate fully with

the Inquiry's investigation. Its submission stated that the Welsh Government had received and responded to two Rule 9 requests, providing what they claim were 'very detailed' statements and substantial disclosure. It is therefore extremely disappointing to see that notwithstanding its public commitment to engage with the Inquiry, behind the scenes the Welsh Government's compliance has waned such that a Section 21 Notice was required to compel evidence from key Welsh witnesses including Sir Frank Atherton, Andrew Goodall, the Welsh Chief Nursing Officers and on NHS data. CBFJ Cymru is grateful to the Inquiry for taking a robust approach on this issue to date and hopes it serves as a shot across the bows of the Welsh Government that it must comply promptly and thoroughly.

7. More generally, the CBFJ Cymru repeats its usual request for the Inquiry team to ensure that Core Participants receive final statements and exhibits in good time ahead of the substantive hearing.

8. CBFJ Cymru looks forward to a further update in respect of the status of Rule 9 requests at the hearing on 10 April 2024 and thereafter will continue to consider the monthly updates to Core Participants on the progress of Rule 9 work.

Spotlight Hospitals

9. The Inquiry intends to focus on a number of 'Spotlight Hospitals' from all four nations of the United Kingdom to better understand the impact of the Covid-19 pandemic on the way in which hospitals functioned during the relevant period.

10. At paragraphs 9 – 14 of Counsel to the Inquiry's Note, it is said that Rule 9 requests have been sent to 22 hospitals across the four nations with two hospitals being chosen in each of Wales, Scotland and Northern Ireland, and 16 from England. It is said that the selection of hospitals is limited due to the need to balance resources and is not designed to identify those hospitals most severely affected by the pandemic, nor is the purpose to conduct an examination nation by nation, region by region or hospital by hospital.

11. The topics to be covered in the Spotlight Rule 9 request is set out at paragraph 13 and are extremely important to CBFJ Cymru.

12. CBFJ Cymru vehemently disagrees with the Inquiry's approach to and selection of Spotlight Hospitals in Wales.

13. A significant proportion of the CBFJ Cymru group lost their loved ones as a result of hospital acquired Covid-19, or in care homes following the discharge of hospital patients without testing. Such is the importance of nosocomial infection to CBFJ Cymru, it has successfully campaigned for an investigation into hospital acquired infection in Wales. It cannot be understated that the impact and management of Covid-19 in hospitals is an issue that sits at the very core of the CBFJ Cymru group.

14. CBFJ Cymru's primary position has always been that a Wales-specific inquiry is required in order to properly assess the impact of the pandemic in Wales. As the Inquiry is aware, despite repeated calls, the Welsh Government has refused to open itself to scrutiny and has evaded the granular inspection of the Covid-19 related issues in Wales, that a Welsh specific inquiry would provide. Against this context, the Inquiry has repeatedly stressed that Wales will be fully considered in this Inquiry, and indeed the Welsh Government has repeatedly relied upon this reassurance as its reason for not granting a Welsh Inquiry.

15. Against the foregoing context, Module 3 is the only opportunity available for robust scrutiny of the impact of Covid-19 pandemic on healthcare systems in Wales. It is therefore imperative that the hospitals chosen as Spotlight Hospitals reflect sufficiently and broadly the dominant and distinct issues which arose in Wales to provide the Inquiry with a larger and more informed evidence base to assist its investigation.

16. To this end, CBFJ Cymru is extremely frustrated and distressed that only two Spotlight Hospitals have been selected from two out of the seven health boards in Wales being Glangwili Hospital, Carmarthen (Hywel Dda University Health Board) and University Hospital of Wales, Cardiff (Cardiff and Vale University Health Board).

17. The National Health Service ('NHS') in Wales is delivered through seven local health boards and three NHS trusts. CBFJ Cymru fails to understand the decision to select these two particular Welsh hospitals and are concerned that evidence from these hospitals will not provide the Inquiry with an accurate and reflective picture of what truly happened in Welsh hospitals during the pandemic.

18. CBFJ Cymru make the following points in particular:

a. Each health board faced unique challenges and responded differently to common challenges over the course of the Covid-19 pandemic, meaning that the key themes and particular issues that arose in Wales cannot be properly understood without broader scrutiny;
b. The suggested approach will not adequately explore the 'post-code lottery' effect in Wales;
c. The rates of nosocomial infection and deaths varied greatly across different health boards and the reasons for this should be explored;
d. A representative understanding of the impact of the pandemic in each corner of Wales cannot be achieved by selecting just two hospitals which may not have experienced the same issues that affected other hospitals and which may not have been impacted in the same way;
e. Concerning/dangerous practices which contributed to the spread of infection and increased deaths in hospitals within the "exempt" health board areas will not be given appropriate scrutiny;
f. The suggested approach fails to take account Wales's unique geographical and demographic characteristics; and
g. Failure to consider variance and the death toll within each respective health board area limits the voice of the bereaved in other areas of Wales.

19. It is notable that the two intended 'Spotlight Hospitals' do not include:

a. Any hospitals from North Wales, where things were much more difficult in terms of facilities and access, meaning the Inquiry will not present a true representation of the particular key issues that impacted a large proportion of the Welsh population. It is notable that Betsi Cadwaladr University Health Board has the highest total number of reported nosocomial cases. The Health Board also has well reported performance issues and was in special measures at the outset of the pandemic until approximately November 2020. Betsi Cadwaladr University Health Board re-entered special measures in February 2023;
b. Any hospitals in Aneurin Bevan University Health Board which covers Newport, which has been described as the epicentre of Wales's Covid-19 outbreak; and

c. Any hospitals in Cwm Taf Morgannwg University Health Board's area, notwithstanding that Rhondda Cynon Taf and Merthyr Tydfil had the highest mortality rates over the course of the pandemic in Wales.

20. Whilst CBFJ Cymru appreciates that the purpose of the Spotlight Hospitals is not to identify the hospitals most severely affected by the pandemic, it is difficult to understand how the Welsh healthcare system's response to the pandemic can be properly considered without appropriate investigation of the above issues.

21. A summary of issues described by some members of CBFJ Cymru is attached at Annex A of this document in support of the submissions made.

22. CBFJ Cymru appreciates the need for a proportionate approach to be taken and does not suggest that every hospital within every health board area needs to be considered. CBFJ Cymru suggests that there should be exploration of <u>one 'Spotlight Hospital' per health board area if the reports are to be meaningful.</u>

23. CBFJ Cymru made detailed representations to the Inquiry team on this issue in the above terms on 2 February 2024, 7 February 2024 and 20 February 2024. CBFJ Cymru is disappointed that notwithstanding the robust arguments advanced, the Inquiry has declined to alter its position.

24. CBFJ Cymru feels despondent with the Inquiry on this issue and perceives a concerning inconsistency with its oft repeated reassurance that issues affecting Wales will be properly scrutinised.

25. CBFJ Cymru repeats its request for further consideration to be given to the selection of Spotlight Hospitals in line with the foregoing submissions.

Impact Evidence

26. The bereaved families have and will continue to provide powerful and valuable information regarding their experiences. They witnessed first-hand the consequences of the catastrophic impact of the pandemic on the care sector in Wales. They witnessed

individual and systematic failures as Covid-19 spread like wildfire through hospitals, fuelled by inadequate infection control including derisory testing regimes, inadequate ventilation and inadequate PPE. It is important that their voices are heard.

27. To this end CBFJ Cymru is grateful for the indication that its members will be invited to give oral evidence at the substantive hearing. CBFJ Cymru will continue to liaise with the Inquiry team to identify the individuals who are best placed to assist the Inquiry.

Disclosure

28. CBFJ Cymru welcomes the update at paragraphs 18 – 21 of Counsel to the Inquiry's note.

29. A significant volume of disclosure has been shared with the Core Participants across 9 tranches of evidence to date. CBFJ Cymru is reviewing the material.

30. In view of the issues being explored in Module 3, the Module 3 disclosure will contain detailed and particularly emotive material upon which client instructions will need to be sought. With this in mind, the CBFJ Cymru repeats its usual request for the Inquiry team to ensure that Core Participants are provided with disclosure as soon as reasonably practicable in order to enable sufficient time for preparation for the substantive hearing.

31. CBFJ Cymru notes that the Inquiry intends to disclose transcripts of evidence from earlier modules which are relevant to Module 3. CBFJ Cymru is willing and able to liaise with the Inquiry to assist in identifying relevant transcripts from Module 2B.

Expert Evidence

32. CBFJ Cymru has provided its comments on the expert report received to date and awaits receipt of the further expert reports.

33. CBFJ Cymru retains its hope that the experts instructed have sufficient experience and expertise to be able to provide evidence dealing with Wales (and the other devolved administrations) specifically.

34. CBFJ Cymru repeats its usual request for the Inquiry team to ensure that Core Participants are provided with the expert reports as soon as reasonably practicable in order to enable sufficient time for meaningful comment and for any further expert evidence dealing specifically with the position in Wales to be obtained (if needed) to be obtained in readiness for the substantive hearing.

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Conclusion

35. CBFJ Cymru will be present at the preliminary hearing on 10 April 2024 and intends to supplement these written submissions with oral submissions.

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25 March 2024

ANNEX A

In order to contextualise the submissions made on 'Spotlight Hospitals', set out below are just some of the lived experiences of CBFJ Cymru's members. Each box contains examples of experiences relevant to a particular hospital within that area.

South Wales

District general hospital: -

- Out of hours GP – GPs failed, on several occasions, to read patients hospital discharge notes which contained key information (e.g. exposure to Covid-19 during stay in hospital).
- One member was unable to say goodbye to their loved one in hospital, even to wave through a window, as their loved one was on the second floor and the hospital wouldn't facilitate video calls.
- One member recalls how their loved one was moved between beds and wards six time within just 8 days of being admitted – he subsequently became infected with Covid but was not tested upon discharge.
- Discriminatory treatment through the use of frailty scoring – one member was told that her mother was being refused oxygen therapy based on her frailty score. Basic administration of antibiotics being refused due to the age of an individual and their chances of survival after receiving a positive Covid-19 result.
- One member recalls her father's DNACPR order being amended without knowledge or consent, to say that her father had agreed to the DNACPR order.
- One member stated that it was written in her father's notes that he had prostate cancer in April 2020. The notes state that it was a contained cancer tumor. A decision was made to delay a follow up appointment/treatment for 6 months. The patient and his family were not told of the prostate cancer. 6 months later, the family were then told of the prostate cancer and a fortnight later, were told that the cancer had spread, and palliative care was now appropriate.
- Another member says their loved one was admitted to hospital for gallbladder removal and was discharged without being tested, having been exposed to Covid. When readmitted to hospital with fatigue and severe diarrhea, they were kept waiting for hours and denied oxygen for an extended period of time.

• Many members have complained about the inadequate complaint's procedures in place. • Notably, these issues continued through Wave 1, into Wave 2 and beyond.
• One member's loved one was initially admitted to one hospital and then moved to this hospital. They acquired Covid in hospital. Our member particularly noted that the experience of their loved one in the first hospital was great – they facilitated Facetime calls with the family. The care received in the subsequent hospital was horrendous. The family were given no information regarding their loved one's final hours and were kept in the dark. No dignity in death. Family given the wrong belongings when their loved one died. Loved one wasn't in a presentable state when they died, covered in faeces. Doctors were rude.
• The loved one moved onto a mixed ward with Covid. They felt their loved one was neglected because they were 'old.' Lost loved one's wedding ring after death. Agency staff were running the ward. Family were told by nurse in charge of the ward (where their loved one died) how embarrassed and ashamed she was of what had happened to patients. • Loved one caught Covid-19 in hospital while recovering from a leg operation. • First wave – members loved one was admitted to hospital for an unrelated covid matter – loved one was moved from one hospital to another – family were provided with misinformation on several occasions. • A loved one was admitted to hospital with a kidney infection and contracted Covid whilst in hospital. • Loved one admitted to hospital for bronchoscopy, received three negative Covid tests in hospital. Patient then caught Covid in hospital and died. • A loved one was admitted to hospital due to a heart condition and possible sepsis. Negative on admission but moved to a Covid ward. Family were unable to see their loved one for 6 weeks whilst in hospital; patient died during second wave.
• Loved one admitted to hospital after having mini stroke. Tested positive for covid 10 days after admission and died from Covid.

General comments:

- This Health Board authorized numerous members of staff to move around hospitals taking photographs of those who were suffering and dying. They even authorized access to morgues where photographs were taken of those who had succumb to the virus in body bags.
- Members recall health care workers going from ward to ward wearing inadequate PPE or failing to collect new PPE as they entered a different part of the hospital. Nurses walking around with face masks on their chins.

- A loved one had cancer and was admitted to hospital for non-Covid related reasons – extremely high risk – placed on amber ward, despite family being reassured that she would be placed on green ward.

South Wales

- Members recall seeing health care workers going from ward to ward wearing inadequate PPE or failing to collect new PPE as they entered a different part of the hospital. Nurses walking around with face masks on their chins.
- Delay in receiving treatment because of age. Waiting 12 hours before vital medication to be administered and 24 hours before being put on CPAP.
- Loved one went in without covid for an operation, was recovering from the operation and due to be discharged, but he caught Covid-19 in hospital and died.
- Loved one was admitted to hospital with a suspected UTI. Placed on mixed ward during second wave. Nurses wearing masks around their chins. Discharged without testing and had symptoms of Covid-19. Visited by GP when back at home – GP didn't use oximeter, no suggestion loved one had covid. Loved one deteriorated, rushed to hospital, delay in administrating CPAP. Didn't treat their loved one with the urgency they deserved, told family on the telephone that he was to be given palliative care and nothing more would be done to save him.

South-West Wales

- Vulnerable person suffering from comorbidities put on general ward after breaking their hip at home. Negative test on admission to hospital, spent approx. 11 days in hospital, sent home and was told he was covid positive when he attended the

fracture clinic 2 days later. DNACPR signed – members loved one said family weren't consulted about DNACPR decision and family raised queries with the Dr re: his state of mind.

- Second wave – loved one was admitted to hospital for unrelated Covid matter, had to wait for 7 and a half hours in excruciating pain on the floor of an ambulance. Negative test when entered the hospital. Placed on main ward although he had an auto immune disease.
- Loved one was admitted to hospital for unrelated Covid-19 issue, placed on a covid free ward but contracted Covid on the ward, 8 days later. Loved one allegedly told family that the nurse told him (once he caught covid) not to share that with the new patients being admitted. Lack of communication with the hospital. The family were shocked and traumatized to learn that their loved one had been filmed by a news channel whilst being treated with CPAP oxygen – saw their loved one on the television without warning or discussion.
- Loved one in hospital for amputation. Operation kept being cancelled. Patient then caught covid, underwent operation, but died from covid a few days later.
- Loved one attended hospital for a minor foot operation, moved from ward to ward, caught Covid and died in ICU.
- Double transplant patient contracted covid whilst in hospital, fought for 7 weeks, 5 on a ventilator. Passed away during latter half of first wave.

South Wales

- Vulnerable patient with comorbidities - hospital acquired Covid, moved from hospital to a smaller health facility. The family kept in the dark – poor communication from the hospital. Lack of PPE worn by nurses. Loved one's wallet went missing.
- A loved one was admitted to hospital, unrelated Covid reason – moved from ward to ward, caught covid and died.
- Admitted to hospital with COPD, negative for Covid on admission and placed on green ward. Tested for Covid on day 3 – still negative. Tested on discharge, day 8, and sent home. Two days following discharge home, home, patient was rushed back to hospital with Covid-19 which they contracted within hospital as later

informed the test upon discharge was positive. Family question how their loved one was infected on a green ward.

- Loved one has MS, paralysed from the neck down. Tested negative for covid on admission and then tested positive upon discharge, second wave. Died December 2020. Family believe virus was brought to her by staff who were not tested before going into work.
- Error in test result meant that members loved one, who was on a Dementia ward, was moved to a Covid ward and died following exposure to Covid.
- Loved one admitted to hospital with blood infection, covid free upon admission. Patient moved from ward to ward, contracted Covid and died in the first wave.

- Loved one spent 4 hours waiting for an ambulance and 12 hours in the back of an ambulance before being admitted to the ward with Covid.
- Loved one admitted to hospital after falling at home, contracted Covid in hospital and died. Admitted to ICU but ventilator refused and DNACPR put in place.
- Loved one suffered with Parkinson's and frailty and therefore vulnerable. In hospital for non-Covid related reason, contracted Covid in hospital. Covid ward was on the opposite corridor, but nurse's station was between both wards.

North Wales

- Loved one was very vulnerable due to COPD, acquired covid in hospital due to infection control issues. Loved one was on an open ward – shouldn't have been due to their vulnerabilities. Poor communication with the hospital, lack of PPE.
- Covid acquired whilst patient was on stroke ward. Died during the second wave.

- Loved one was in hospital undergoing an operation and discharged to this local community hospital to recuperate. Caught Covid in hospital – possibly due to lack of PPE and moving people around without testing. Patients' medical notes report 1 positive and two more possible cases on the ward.

- Loved one tested positive for Covid whilst at hospital. Hospital wanted to carry out DNACPR against sisters wishes despite POA. Passed away in hospital.

• Loved one was negative for Covid on arrival at hospital, moved around 5 different wards. Died from Covid latter half of first wave.
West Wales
• Loved one had cancer and was admitted to a cancer ward. Vulnerable and ended up catching covid on cancer ward. Underwent many tests before the hospital concluded it was cancer. Lack of communication between hospital and family – no empathy shown.
• Second wave - loved one contracted Covid-19 after an outbreak on the hospital ward. Poor communication between hospital and family. Hospital staff seen attending supermarkets in their scrubs. • Loved one was patient in stroke unit, infected with covid at hospital and died alone.
• Loved one admitted to hospital due to low SATS, placed next to Covid positive patient on ward despite having COPD, heart disease and diabetes. Poor communication between hospital and family.