BEFORE BARONESS HEATHER HALLET

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

CLOSING STATEMENT

ON BEHALF OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU

MODULE 3

INTRODUCTION

1. These submissions are made on behalf of Covid-19 Bereaved Families for Justice Cymru ('CBFJ Cymru'). They supplement the evidence already provided to the Inquiry pursuant to r.9 Inquiry Rules (INQ0000486000; INQ000343992; INQ000486273) and in oral evidence [2/145/11 – 2/177/17]; [39/1/1 – 39/33/9].

2. CBFJ Cymru is a group of bereaved families which came together to campaign for truth, justice, and accountability for all those bereaved by Covid-19 in Wales, following the devastating loss of their loved ones in the most traumatic of circumstances. Since its establishment, CBFJ Cymru has become the most prominent organisation in Wales in the discourse surrounding Covid-19. CBFJ Cymru continues to fight for proper scrutiny decision-making relevant to Wales, particularly that of the Welsh Government.

3. The preparedness of the United Kingdom for a pandemic (the subject matter of Module 1) and political decision-making by the UK Government and Devolved Administrations (the subject matter of Module 2 and its submodules) are key matters of context for the subject matter of Module 3 and these submissions.

4. In its Module 1 Report published July 2024, the Inquiry found (inter alia) that *"the UK was ill prepared for dealing with a catastrophic emergency, let alone the coronavirus (Covid-19) pandemic that actually struck"* and that going in to the pandemic the UK lacked resilience and in particular *"public services, particularly health and social care, were running close to, if not beyond capacity in normal times"*. The Inquiry found that emergency planning structures were "*labyrinthine in their complexity"*, there were *"fatal strategic flaws underpinning the assessment of risks faced by the UK", a "failure to learn sufficient from*

past civil emergency exercises", a *"damaging absence of focus on the measures interventions and infrastructure required in the event of a pandemic – in particular, a system that could be scaled up to test, trace and isolate in the event of a pandemic"* and *"lack of adequate leadership, coordination and oversight"* by Ministers.

5. In respect of Wales specifically, the Inquiry noted that "*For an administration that prided itself on its efficiency of movement because of its relative lack of scale, and which had described itself as operating, effectively, "under one roof", the reality did not match the rhetoric. The system was labyrinthine. The Inquiry was not persuaded by the mitigation offered by Dr Goodall that it made more sense to those within the system than those outside of it. An opportunity to create a coherent and, therefore, dynamic system in Wales had been hampered by undue complexity."*

6. In summary, the Inquiry had "*no hesitation in concluding that the processes, planning and policy of the civil contingency structures within the UK government and devolved administrations and civil services failed their citizens".*

7. The evidence in Module 2 and 2B underscored the passive, slow and disjointed response to the Covid-19 pandemic by the UK Government and Welsh Government. There were clear warnings that from January 2020 what was happening globally could occur in the United Kingdom. In Wales, Sir Frank Atherton had warned the First Minister by 24 January 2020 that "*there was a significant risk the virus would arrive in Wales*" ([M2B] INQ000371209_0023 paragraph 27). The UK Government and Devolved Administrations should have been electrified into action from the end of January / start of February 2020 onwards. It is clear from the evidence the UK Government and Welsh Government failed to grapple with the nature and extent of the risk posed. In particular, the Welsh Government were unacceptably slow to accept and respond to the science, most notably to the possibility of asymptomatic and airborne transmission.

8. Against this context, CBFJ Cymru turns to consider how the healthcare system in Wales fared during the pandemic.

9. On the evidence before the Inquiry in Module 3 (including the evidence of the eight Welsh oral witnesses) there can be no doubt that the Welsh Government and NHS Wales performed poorly.

SUBMISSIONS

10. CBFJ Cymru submits that the following high-level findings are supported by the evidence before the Inquiry in Module 3 and relevant to Wales:
    a. The healthcare response in Wales was ultimately the responsibility of the Welsh Government in the relevant period;
    b. The healthcare response to Covid-19 in Wales was inadequate;
    c. The Welsh Government had sufficient notice, knowledge, and warning of the risks to the lives of people in Wales arising from Covid-19 but failed to take adequate steps to prepare NHS Wales and to support it to respond proactively; and
    d. The Welsh Government has failed to learn lessons.

11. The following submissions are aimed to assist the Inquiry's consideration of its findings: the factual narrative and lessons to be learned in Module 3. The submissions cover:
    a. Accountability in the healthcare system in Wales;
    b. IPC Guidance;
    c. FFP3 Masks;
    d. Testing;
    e. Escalation of Care;
    f. DNACPR;
    g. Access to GP Services;
    h. Shielding;
    i. Compassionate Care and Dignity in Death; and
    j. Recommendations.

ACCOUNTABILITY IN THE HEALTHCARE SYSTEM IN WALES

12. CBFJ Cymru is disappointed that there has yet again been a failure by the Welsh Government to account for what went wrong in Wales. Whether this be the failure to complete comprehensive lookback exercises, a failure to provide key documents to the

inquiry, or the failure of Welsh witnesses to meaningfully reflect or show contrition, there has been a systemic failure in accountability.

13. The Welsh Government and NHS Wales's woeful approach to learning lessons is best demonstrated by its failure to conduct a national lessons learned review. In stark contrast to the approach of other UK Nations, the lookback exercises in Wales have been piecemeal; a patchwork of reviews carried out by different bodies without cohesion or focus; all of them superficial, none of them getting to the heart of what went wrong. Staggeringly, some Welsh witnesses have staunchly stood by the lessons learned work done in Wales. Others, such as Baroness Morgan suggest that the Welsh Government is simply waiting for the Inquiry to report first. While the Inquiry is certainly an important process, it is deeply concerning that the Welsh Government would not want to understand for itself what went wrong in Wales, would not want to armour up as soon possible for the next pandemic.

14. The lax approach to learning lessons in Wales is also illustrated by the, at best, cursory exploration of nosocomial infection. Wales established a National Nosocomial Covid-19 Programme, purportedly to investigate individual patient safety incidents of nosocomial Covid-19. The Welsh Government, through Judith Paget gave no meaningful assurance that all cases of nosocomial deaths had in fact been recorded as patient safety incidents. There has been no national oversight. Further, Eluned Morgan, Judith Paget and her predecessor Andrew Goodall, were somewhat nonchalant as to the absence of a national investigation into cluster outbreaks in Wales. The failure at national level to look at the root causes of clusters outbreaks, represents a clear missed opportunity to identify patterns and potentially life-saving interventions.

15. CBFJ Cymru considers that the inadequacy of the Welsh Government's approach to lessons learned is compounded by its continued failure to open itself up to detailed scrutiny by this Inquiry. CBFJ Cymru has long highlighted concerns that Welsh Government has cherry picked the disclosure it sends to the Inquiry. Separate written submissions dated 29 November 2024 have been made by CBFJ Cymru to the Inquiry in Module 2B which emphasise the nature and extent of the issue. This concern has followed through to Module 3. Vaughan Gething, in his oral evidence, told the inquiry that his discussions with Chief Executives of Health Boards, the CNO, and CMO were minuted, but for reasons that are

not clear to CBFJ Cymru, these minutes have not been disclosed to the Inquiry [35/66/13-23] . This is unacceptable and a complete derogation of transparency.

16. CBFJ Cymru considers that the oral evidence given to in this Module can be characterised by a reluctance in many quarters of Welsh Government and NHS Wales to give open accounts of what went wrong and why, and to accept that mistakes were made – which they undoubtedly were.

17. A feature of this Inquiry has been to highlight that the system in Wales is plagued by blurred lines of accountability which in turn allows for finger pointing instead of answered questions and pro-active action. Notwithstanding that the Welsh Government accepted within its opening statement to the Inquiry that responsibility ultimately rested with them, Welsh Government witnesses have repeatedly deflected responsibility and criticism by deferring to the operational arrangements of the Health Boards who in turn, appear to have been looking to a rudderless Welsh Government for clear guidance and national oversight which did not always materialise.

18. Whilst the Welsh Government and NHS Wales congratulate themselves for things that were done well, CBFJ Cymru says this is because they have not looked closely enough at what went wrong and there remains a wide gulf within which nobody is willing to take responsibility in Wales.

19. Within its oral closing, the Welsh Government has teased a potential acceptance that not all decisions-taken in Wales worked, noting vaguely that issues have emerged or crystallised in respect of NHS capacity; critical care capacity; availability and distribution of PPE; field hospitals; nosocomial transmissions and services available to treat long covid. Frustratingly, the Welsh Government elaborated no further. CBFJ Cymru looks forward to receiving the detail within the Welsh Government's Written Closing.

20. In terms of recommendations, the Welsh Government suggest that "less is more". With respect, given its poor track record for reflection and learning lessons to date, CBFJ Cymru considers that for the Welsh Government "less would in fact just mean less" and there is clearly a need for a suite of substantive recommendations which go beyond the Welsh Government's current proposals if there is to be meaningful change in Wales.

21. With this in mind, we turn to some of the principal issues of concern for CBFJ Cymru.

IPC GUIDANCE

22. First, the Infection Prevention and Control Guidance simply did not address the risk posed by Covid-19; an airborne virus. In particular, from 13 March 2020, the only airborne precautions related to wearing FFP3 masks where AGPs were being conducted (INQ000474282_0060). In the iteration of the guidance dated 6 March 2020 (INQ000339123_0003), it was said that "*Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions*" which was likely to give the misleading impression that the main routes of transmission were the droplet and contact route. In fact, the science was far from clear on that point. In a NERVTAG meeting on 3 February 2020, Professor Van Tam acknowledged that "*we do not understand the relative contribution of fine particles [...]*" and other members agreed that they were making assumptions based on other respiratory pathogens (INQ000119615_0004). Dr Ritchie further confirmed in her evidence that they were basing the response to Covid-19 on its nearest relative, SARS (INQ000421939_0025 paragraph 91). The RPE required when dealing with a number of different pathogens, including SARS, was considered in a paper co-authored by, inter alia, Dr Ritchie and Professor Van-Tam published on 17 September 2013. The mode of transmission is said to be "Droplet/aerosol" with the RPE to be worn is specified as FFP3 respirators ("FFP3s") until the patient is no longer considered infectious (INQ000130561_0005). Accordingly, those responsible for developing the IPC Guidance should have proceeded on the basis of the existing science which was that coronaviruses are airborne and the relative contribution of the different routes is uncertain.

23. In fact, the guidance dated 6 March 2020 goes as far as to say that "*Emerging information from these experiences has highlighted factors that could increase the risk of nosocomial transmission, such as delayed implementation of appropriate infection prevention and control measures combined persistence of coronavirus in the clinical setting*" (INQ000348309_0002) yet staggeringly failed to identify Covid-19 as airborne. This is a position which became entrenched and took a long time to be severed from the IPC Guidance.

24. The iteration of the Guidance dated 18 June 2020 continued to include erroneous statements such as "*Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak. [...] The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. The predominant modes of transmission are assumed to be droplet and contact*" (INQ000300300_0011). Those responsible for drafting the Guidance must have known that this statement was incorrect, firstly, because SARS-CoV was thought to be airborne (see above), and secondly, because, by this stage, the Environmental Modelling Group chaired by Professor Noakes had already reported to SAGE that there was a risk that SARS-CoV-2 was transmitted via aerosols. Indeed, from 5 June 2020, Public Health England stated that all hospital visitors and outpatients should wear face coverings, and all hospital staff should wear surgical masks in all clinical areas by 15 June 2020 "*to prevent the spread of infection from the wearer*" (INQ000474282_0060). Clearly there were people in some quarters who had realised that aerosol transmission was a risk. The only reason why this updated knowledge did not make its way into the IPC Guidance is because people on the IPC Cell, including its chair, Dr Ritchie, did not believe that Covid-19 was transmitted via the airborne route, but via droplet and contact. In fact, Dr Ritchie maintained this stance up and until her evidence in this Module [5/62/1 – 5/186/5).

25. As a result, the Guidance was grounded in the flawed scientific view held by those such as Dr Ritchie that Covid was transmitted via droplet and contact. As a result, insufficient consideration was given to appropriate risk mitigation measures.

26. In particular, there was insufficient consideration given to ventilation beyond the opening of windows. Dr Shin in his oral evidence recommended common-sense alternatives to installing new ventilation, namely UV filtration system and HEPA filters [08/172/3 – 08/174/4] which were low cost and portable. Baroness Morgan flippantly joked that a HEPA filter had been her most disappointing Christmas present [35/195/6-8]. On the contrary, for CBFJ Cymru, HEPA filters are a valuable piece of equipment which could have reduced nosocomial transmission rates and potentially saved lives.

27. In addition to its failings regarding mitigation measures to address aerosol transmission, the Guidance demonstrated an erroneous and dangerous lack of appreciation of the potential for asymptomatic transmission.

28. Dr Warne's evidence was that "*absolutely*", future guidance should assume there to be asymptomatic transmission until the contrary is proven, particularly in light of the evidence of asymptomatic transmission in a range of respiratory viruses, including influenza and RSV [08/23/15 – 08/24/14]. Not only should this have been assumed, but there was some evidence to support this assumption from early on in the pandemic. The evidence from the WhatsApp group from the CMOs demonstrates that, as early as 28 January 2020, Professor Sir Michael McBride had identified that there was evidence "*consistent with asymptomatic transmission during the incubation period*" (INQ000375354_0001). Professor Sir Chris Whitty replied on the same day stating "*Agree. Compatible, probable but not conclusive. […] But we should now assume it may be happening*" (INQ000375354_0002). If that should have been the working assumption, CBFJ Cymru queries why this is not properly reflected within the IPC Guidance. In particular, not enough thought was given to the fact that every patient represented a potential risk, rather than simply those who had tested positive for Covid-19, or who were presenting with symptoms.

29. As to what was meant by "presenting with symptoms", there was too rigid an adherence to the "cardinal symptoms" when there was evidence that, particularly in the case of older people, who didn't always present with fever or chills, cough, and shortness of breath. Instead, they may present with symptoms such as extreme fatigue, headaches, nausea, and/or diarrhoea. Those in charge should have taken greater care to ensure that clinicians understood that Covid-19 did not always present with the three "cardinal symptoms" and to be on guard for other symptoms. The evidence of Miss Marsh-Rees is that in Wales, the three symptoms that were identified on the 111 service were fever or chills, a persistent cough, and shortness of breath and anything outside of those three symptoms that wasn't recognised as a potential symptom of Covid. *Ms Marsh-Rees said "I think many older people don't display those three cardinal symptoms and they, you know, it is extreme fatigue, it's headaches, it's nausea, it's diarrhoea, and some others. We're not suggesting that everybody should have, you know, gone to hospital or needed a test with everything, but the lack of acknowledgement that those were Covid symptoms and, you know -- and it was definitely acknowledged they were by October 2020. It was a real miss"* [39/6/21-

39/7/4]. If Covid-19 positive people did not get tested because they did not present with those symptoms, this presented fertile ground for the incubation and spread of Covid-19 in hospitals. Further, even where there was evidence of Covid-19 symptoms, our members are aware of healthcare workers doing nothing to segregate those individuals or impose further protections until the test confirmed, they were positive.

30. The IPC Cell, though not a decision-making body, became a de facto decision-making body because their recommendations were not challenged. As a consequence, the fundamentally flawed IPC Guidance was simply adopted by decision-makers in Wales without question. In fact, Sir Frank Atherton described the challenge as "*managing the interface*" between the IPC Cell and the rest of the system in Wales [13/41/1-3] which indicates that he saw his role as one of mediating, rather than an acting as an important check and balance to ensure that appropriate IPC Guidance was being implemented in Wales.

31. CBFJ Cymru finds this particularly concerning given that Sir Frank Atherton and the Welsh Nosocomial Transmission Group took a completely different view on the science regarding transmission. For example, in evidence, Sir Frank Atherton suggested that it was understood from a fairly early stage that there was a continuum of droplets to small particles to tiny particles [13/117/4-9]. Despite this, not once did Sir Frank Atherton or the Nosocomial Transmission Group challenge the IPC Guidance or describe it as inadequate. If Sir Frank Atherton did consider that there was at least a risk that Covid-19 was airborne, it is not clear to CBFJ Cymru how he could have considered Guidance which was predicated on the mode of transmission being predominantly contact and droplet, save in the case of AGPs, adequate.

32. Further, Public Health Wales were represented on the IPC Cell and indeed Dr Eleri Davies of Public Health Wales was the Chair from 31 March 2021. We have not heard evidence from Dr Eleri Davies, nor was a rule 9 request sent to her. However, we know that no significant changes were made to the IPC Guidance to address aerosol transmission following her appointment as Chair. This suggests that either Dr Davies agreed with Dr Ritchie's view as to the mode of transmission (apparently contrary to the views of others in Wales), or she understood the part played by aerosol transmission but somehow concluded that the Guidance was sufficient despite the absence of sufficient measures to address the risk.

33. It is unclear to CBFJ Cymru whether the lack of challenge is indicative of the cultural problem in scientific advisory groups in the UK whereby advice becomes mired in groupthink, or whether it was because the wrong people were making the decisions about IPC. Laura Imrie suggested that she did not think that it was the role of IPC guidance to look at ventilation as no member of the group felt that they were qualified to comment on ventilation which suggests a remarkable lack of proper expertise on the IPC Cell.

34. A further key issue with the guidance was the way in which changes were and conversely were not made to it. There were many iterations of the IPC guidance which likely contributed to confusion and non-compliance by healthcare workers. Dr Shin said in evidence that "*If the evidence changes significantly, as we've heard, then it's right and proper to create, to generate and cascade correctly formatted guidance. But there [...] were occasions when new iterations came out it was quite hard to see the differences, and later on in the pandemic it was highlighted which bits changed but sometimes the changes were quite subtle, so it did beg the question sometimes: why is this version needed?*" [8/93/22 – 8/94/7] . While many of the changes were minor and likely of little consequence, there were significant changes which should have been made to reflect the evolving scientific knowledge surrounding aerosol and asymptomatic transmission, however, these were not made in a timely manner or at all. In particular, it took until 1 June 2021 to allow healthcare workers to wear FFP3s if local risk assessments concluded that an unacceptable risk of transmission remained (INQ000474282_0060).

35. Further, there was a lack of openness and honesty about the way in which the changes were communicated, particularly in relation to decisions to downgrade the requirement for all healthcare workers treating Covid-19 patients or suspected Covid-19 patients to wear FFP3s to FRSMs. Professor Gould stressed the importance of transparent communication in this regard; *"[...] it might be very difficult to provide everybody with a high-quality face mask because they might just not be available. So you would downgrade that recommendation, but you would have to say why. [...] So you can upgrade or downgrade your recommendation, but you have to show how you reached that conclusion*" [8/78/6-18]. Dr Barry Jones echoed this sentiment: "*If on March 13 2020 the powers that be that told us it was only droplet and surgical masks were fine and will protect you perfectly well against an airborne thing had actually said "Look, it's tough, there's a world shortage of PPE", we*

would have understood" [4/42/10-15]. Instead, an intellectually dishonest line was taken by those responsible for developing IPC Guidance.

36. As a consequence, there is evidence that healthcare workers did not accept the Guidance intellectually. Professor Gould noted that "*emotionally and intellectually people need to accept that the guideline does genuinely represent best practice*" [8/66/5-7] and that, "*intellectually, people didn't always trust the guidelines*" [8/83/24-25]. This was made particularly stark in the evidence of Ms Nicholls who said, "*It felt like a big echo chamber and what our members were telling us in huge volume is that it didn't feel right on the ground*" [9/80/1-3]. CBFJ Cymru suggests that the reason healthcare workers did not accept the guidance intellectually was because the means of arriving at it was intellectually dishonest and involved those responsible for developing the Guidance holding onto increasingly indefensible decisions in light of the developing scientific picture.

Implementation of IPC Guidance

37. The Welsh Government had long been aware that the NHS estate in Wales was barrier in the implementation of effective IPC measures more generally. These difficulties were brought into sharp focus when the pandemic struck. Notwithstanding this, little was done by NHS Wales to mitigate the concerns relating to the NHS estate to ensure effective implementation of the IPC Guidance, and little was done by the Welsh Government to ensure national oversight on the issue. This represented a missed opportunity.

38. Many of CBFJ Cymru's members witnessed healthcare workers failing to adhere to IPC guidance, most notably failing to wear the correct PPE appropriately or at all. A concerning discrepancy has emerged between healthcare workers and operational leads as to the availability of PPE in the early stages of the pandemic. Policy and operational leads insist that there were no supply issues yet healthcare workers report that they felt unsafe in work due to non-availability of PPE. Where PPE was available, there is no evidence before the Inquiry as to what was being done to mitigate compliance and complacency fatigue and ensure that staff wore PPE correctly. Ultimately, non-compliance with Guidance was not acceptable and placed vulnerable patients at avoidable risk and more should have been to prevent it.

39. CBFJ Cymru is further concerned by the lack of proper segregation of patients in Welsh hospitals. Though there was supposed to be a Traffic Light system in place, those we represent witnessed non-Covid patients placed on Covid wards, Covid patients placed on non-Covid wards, people in corridors, an inconsistent utilisation of those categories. Members intervened to ask for their loved ones not to be placed on a Covid ward, including one family member who was immunosuppressed. They were still placed on a Covid ward, where they contracted Covid and died. Suspected Covid patients were also kept on wards until they tested positive. A total failure of common sense.

40. A Welsh Government report disclosed to the Inquiry states that "*Nosocomial transmission of COVID-19 is unfortunately widespread in health boards/ Velindre Trust across Wales. Hospital transmission of COVID-19 has been a major safety and quality concern for all NHS organisations since the start of the pandemic. Actions to address this need to take account of the multiple factors that influence hospital transmission and the particular nature of the virus itself. In the week ending 14/2/21, a Wales total of 211 hospital onset cases (definite or probable) were reported. This represents 8% of all confirmed COVID-19 cases and 53% of total COVID cases within Welsh hospitals*" (INQ000227307_0001).

41. What is particularly mystifying for those we represent is that nosocomial transmission was worse in the second waves (INQ000227307_0001), despite there being a period in the Summer of 2020 where lessons should have been learned from the first wave. Instead, no lessons were learned. The rates of nosocomial transmission in hospitals increased and more people died as a result.

42. The evidence betrays a belief that nosocomial transmission was an inevitability. There were a number of witnesses who were reluctant to accept that the point of IPC is to reduce nosocomial transmission. Sir Frank Atherton, when asked whether the issues with frequent or repeated hospital outbreaks was an indication that the IPC measures were either not effective or not being implemented, said "*In hospital settings it's impossible to completely eradicate nosocomial transmission. […] You will never eradicate it but you should reduce it as much as you possibly can*" [13/52/5-18]. The problem with this position is that there does not appear to ever have been a decision taken by the Welsh Government or anyone responsible for the NHS in Wales for what an "acceptable" level of nosocomial transmission might be. Therefore, there is no benchmark against which to measure what

amount of nosocomial transmission is inevitable, and what is avoidable. This fatalistic approach is made clear in the NTG internal audit service report dated 1 September 2021, where it is said "*The NTG ... routinely monitors rates of transmission, as discussed below, but not with the expectation there is a direct correlation between the guidance issued and lower infection rates*" (INO000022598_0003). When asked about this, Sir Frank Atherton said, "*you'll have to ask the internal audit people*" [13/64/15-16]. This evidence underlined the concern of CBFJ Cymru that the Guidance was merely a sticking plaster covering a festering wound.

FFP3 MASKS

43. If the IPC Cell were proceeding on the basis that the measures should reflect that which would be in place for SARS-CoV, then FFP3s should have been recommended for healthcare workers treating Covid-19 patients and suspected Covid-19 patients. This was the recommendation from the 2013 paper co-authored by Dr Ritchie, in which it was noted: that "*Surgical face masks provide a barrier to splashes and droplets impacting on the wearer's nose, mouth and respiratory tract. They do not provide protection against airborne (aerosol) particles and are not classed as RPE*" whereas "*A respirator is used by an individual to provide respiratory protection. [...] Although most of the evidence base supporting the use of FFP respirators in the prevention of airborne transmission of infection is based upon N95/FFP2 devices, FFP3 is the only FFP class acceptable to HSE for use against infectious aerosols in health care in the UK (Appendix 3). In the USA, N95 (approximately equivalent to FFP2) is acceptable, as is the case in a number of other countries*" (INQ000119615_0003).

44. However, the reason why there was a downgrading of the recommendation remains unclear. If the reason was lack of availability, decision-makers should have been honest about this. Instead, the witnesses have sought to suggest that there is in fact a lack of evidence to support the recommendation to wear FFP3s. Both Professor Susan Hopkins and Professor Chris Whitty gave evidence which was dismissive of the evidence which suggests that FFP3s afford a greater degree of protection. Their rationale was that the evidence demonstrating that FFP3s afford a greater degree of protection is confined to laboratory studies, the implication being that these studies are not reliable. However, there are numerous reasons why that which was established in a laboratory setting may not have been

reflected in clinical studies; the clinical studies may not appreciate that healthcare workers are wearing the masks incorrectly or inconsistently, and they may not reflect the fact that healthcare workers take off their masks in break areas. The lack of evidence from clinical studies does not undermine the clear evidence that FFP3s provide more protection if fit-tested and worn properly. As to this issue, CBFJ Cymru relies upon paragraph 187 of Professor Beggs's report (INQ000474276_0074).

45. CBFJ Cymru submits that decision-makers became too tied to the need for a high level of evidence to prove that FFP3s were more effective. What was needed was a common sense approach. When people's lives are at risk, it is better to be safe than sorry. Further, there was too much focus on FFP3 or FRSM. Where it was not realistic to provide FFP3s in all circumstances, consideration should have been given to recommending FFP2s as an alternative to FRSMs. The extent to which the availability (or otherwise) of FFP3s was driving policy decisions remains a real concern to CBFJ Cymru, especially in light of the minutes of the IPC Cell discussion on 22 December 2020 where one member said: "*If we increase the use of FFP3 masks we need to consider stock availability, as this could put additional pressure on Trusts*" and another member said "*Our understanding of aerosol transmission has changed. A precautionary approach to move to FFP3 masks whilst we are awaiting evidence should be advised*" (INQ000398244_0003), however, this does not appear to have been the consensus view as no such recommendation was ever made.

46. As to the stance that FFP3s should only be worn when AGPs were taking place, this strict dichotomy in the Guidance between AGPs and any other activity further undermined the rationale for the Guidance when it would have been instinctively clear to healthcare workers on the ground that no such strict dichotomy exists. This was confirmed by Dr Warne's evidence that simply coughing generates aerosols [08/51/2-24]. This stance is further undermined by the study conducted by HSJ Intelligence which demonstrates that anaesthetists and intensive care doctors who were working in AGP hotspots while wearing FFP3 masks were at less risk than staff working on general wards (INQ000352887_0008). It is posited in an article published in Clinical Medicine (INQ000352883) that a reason why those thought to be at the highest risk of infection but who did not demonstrate higher levels of mortality was that they were wearing proper RPE.

47. The IPC experts recommended that, in future, where there is a suspected or confirmed respiratory virus, the guidance should include routine use of FFP3 [8/41-44]. CBFJ Cymru adopts this recommendation.

TESTING

48. A key measure for reducing nosocomial infection is the routine testing of asymptomatic healthcare workers and patients.

49. We have heard from many witnesses, including Dame Ruth May, that testing played a vital role in reducing nosocomial transmission. Dame May spoke in her evidence about the importance of staff testing and recommended greater consideration of *testing because not only would visitors have been back earlier, staff would have been safer but patients would have been safer too* [6/89/17-20]. The importance of testing was also acknowledged by the Chief Nursing Officer for Wales, Jean White who stated when asked about the importance of testing:

Absolutely. If you want to try to enable the system to keep delivering other care, you need to separate out those folk who have got an infectious disease from those folk who don't, so that you're able to have, I hate to say, sort of a clean system, but those not affected. I don't know what language I should use here which doesn't sound inappropriate, but you understand what I'm trying to say [6/122/5-12].

Testing of Healthcare Workers

50. Despite this, Wales was later than England in introducing PCR testing of asymptomatic healthcare workers and were also later in introducing routine testing of healthcare staff when Lateral Flow Tests became available. Routine testing of all healthcare staff was introduced on 16 November 2020 in England. It was not until 4 December 2020 that the Welsh Government's policy requiring routine testing of all healthcare workers was announced with implementation following much later.

51. The evidence before this Inquiry is that the Welsh Government knew about the importance of regular testing as early as May 2020. On 4 May 2020 there was a senior clinicians group

meeting, of which, Sir Frank Atherton was a member. It was emphasised at that meeting "*Need to be really clear why we will not test all HCWs*" (INQ000398255_0008). Further, notes of a meeting attended by Sir Atherton with the Royal College of Surgeons suggests that Sir Atherton recognised "*that facilities can't be kept completely covid-free but keeping them covid-light comes back to testing and how testing is used.*" Sir Atherton also recognised in that same call that there was a need for "*updated guidance and significantly data on risk, especially hospital transmission rates…*". To epitomise the woeful system in Wales, the Royal College of Surgeons expressed in response to its meeting with Sir Atherton that "*astonishingly if someone tests positive for Covid-19 it doesn't automatically go into their patient records. They are responsible for telling their GP etc if they have tested positive (0 Jesus wept...)*" (INQ000409291_0001).

52. Prior to the Inquiry, the Welsh Government has long provided different excuses for the delay in introducing routine testing of staff. When asked about the delay by BBC Wales Live in November 2021, Chris Jones the DCMO seemingly downplayed the importance of routine testing[1]. It is understood that Eluned Morgan had earlier told Radio Wales Drive that the delay was occasioned by the need for a strategy[2]. CBFJ Cymru considers both responses entirely unsatisfactory and hoped that greater clarity would be forthcoming within this Inquiry. Unfortunately, this has not come to pass.

53. When asked for clarity as to the reasons for the delay in this Inquiry, the Welsh Government has continued to provide a range of unsatisfactory and confused excuses. Sir Frank Atherton took little responsibility and instead blamed the UK Government, suggesting that policy leads at UK level didn't communicate rapidly with their counterparts in Wales, stating:

Testing was a bit of an issue, the testing strategies generally, I mean. Although information on the public health basis flowed very smoothly, I think, between the Chief Medical Officers, sometimes – because the work -- understandably, because the work was being undertaken so rapidly, sometimes policy leads at UK level, in England, let's say, didn't communicate as rapidly as I would have liked with colleagues who were working on similar issues in Wales and that did lead, I think, to some divergence and some difficulties in keeping up with everybody was doing. [13/26/3-13].

[1] https://www.bbc.co.uk/news/uk-wales-politics-59247429
[2] ibid

54. A different excuse was suggested by Andrew Goodall [31/ 56/1-17] and Vaughan Gething [35/112/22 – 35/113/14] grounded in the absence of LAMP technology in Wales, but this does not explain the delay in implementing regular testing with lateral flow devices which were available to all four nations from the same date.

55. A further view was offered by Dr Susan Hopkins who suggested in her evidence to the inquiry that "*Wales made the decision that regular testing of healthcare workers was something where they thought there were other interventions they wished to do before this* notwithstanding that Wales *agreed with the early evidence that it was providing an effective route to reduce transmission from HCW to HCW*" [7/220/6-11].

56. The reason for the delay in the introduction of routine testing of all healthcare workers in Wales therefore remains unclear and is inexcusable.

57. To compound the delays, despite the Welsh Government's announcement in December 2020, the roll-out of routine testing of **all** healthcare workers Wales did not in fact commence until January 2021 and was not implemented on the ground until as late as August 2021 in some cases as per the evidence of Professor Kloer [30/162/12 – 30/164/18].

58. When asked whether the delay in implementation exposed patients to the risk of infection from healthcare workers, Dr Warne, Professor Gould, Dr Shin opined that this would have "*increased the risk of transmission from healthcare workers – asymptomatic healthcare workers to patients*" [8/184/14-16].

59. Against this context, CBFJ Cymru has endeavoured to understand why there was a delay in implementation.

60. Professor Kloer's written evidence (INQ000475209_0016) describes operational difficulties surrounding implementation of the Welsh Government's policy as follows:

At the time of this announcement there were no secure supply lines, or reporting system, in place for the delivery and processing of LFDs. There were also concerns about LFD's

sensitivity and specificity. The second wave of Covid was rapidly accelerating and staffing issues were to the fore. Accordingly, the HB's Executive Team took a considered decision not to introduce immediate general staff screening, which have would have involved around 9,000 HB staff plus primary workers, but a phased approach whilst the reporting system for LFDs was fully digitalised. There was an added concern that the manual inputting of data, then necessary for LFD processing, would divert resources from the vaccination programme, then a HB priority, and any false positives generated by the testing programme, an unknown, would further stress an already depleted workforce.

61. These operational difficulties ought to have been known to the Welsh Government through stakeholder engagement and strategic plans implemented in advance of the announcement to assist NHS Wales in the delivery of Welsh Government policy. On the contrary, it is deeply concerning that senior witnesses such as Vaughan Gething did not appear to be aware of the delay in rolling out routine testing until evidence heard in this Inquiry. When asked if he accepted that the delay in the introduction of routine testing was unacceptable, Vaughan Gething stated "*Yes, that -- I was surprised by that evidence, because I would have expected for something like that that I'd have been made aware and that Welsh Government officials would have been aware as well about the fact that there was a different choice being made. As far as I recall, nobody came to me and said, "This isn't happening and nothing is being done about it". So I was surprised at that part of the evidence from Dr Kloer"* [35/113/22-35/114/5]. This begs the question as to why Welsh Government wasn't taking proactive steps to monitor the rollout of the testing programme and ensuring that Welsh Government policy was being implemented.

62. Another example of Welsh Government's chaotic and 'hands off' approach to testing can be found in the evidence of Professor Jean White. Professor White was not only Wales's Chief Nursing Officer but also Co-Chair of the Nosocomial Transmission Group. Notwithstanding these important roles, Professor White stated that she "*played no role"* in ensuring the testing of nursing and midwifery staff [INQ000480133/0100]. CBFJ Cymru struggle to understand why this would not be her responsibility. Whose responsibility should it have been? The answer to that remains unclear. Professor White also displayed a worrying ignorance of the scientific understanding of the virus and the difficulties in the implementation of routine testing of healthcare staff in Wales. When asked to account for the delay in introduction of routine testing of healthcare staff until 2021, Professor White

stated, *"I think the issue is more around asymptomatic testing because at the early days we didn't know that the disease could be spread by those who weren't showing any symptoms and therefore you didn't know that they had it in order to spread it"* [6/123/8-12], notwithstanding that asymptomatic transmission was clearly recognised as early as January 2020 (see paragraph 28 above).

Patient Testing

63. Wales was also later than other UK nations in introducing regular testing for patients.

64. The Welsh Government's main guidance in respect of patient testing was given in March 2020 (INQ000048570), June 2020 (INQ000299363), July 2020 (INQ000275673) and January 2021 (INQ000227387) but a Patient Testing Framework was not issued until March 2021 (INQ000081893).

65. The initial guidance in March 2020 only recommended testing of patients requiring overnight admission if symptomatic (INQ000048570).

66. On 3 June 2020 the 'A principles framework to assist the NHS in Wales to return urgent and planned services in hospital settings' (INQ000299363) guidance was introduced which recommended testing as follows:
    a. *Emergency Admissions: all patients should be tested on admission. For patients who test negative, further testing should be undertaken if COVID-19 symptoms are present / develop.*
    b. *Elective Admissions (including day surgery): Plans should be developed for patient self-isolation and pre-admission testing Patients (conducted a maximum of 72 hours in advance) taking into account the type of procedure / treatment to be undertaken.*
    c. *Inpatients: any inpatient who becomes symptomatic, who has not previously tested positive, should be immediately tested as per current practice*
    d. *Outpatients / diagnostic interventions: testing and isolation to be determined locally, based on patient and procedural risk.*
    e. *Discharge: all patients being discharged to a care home or a hospice should be tested prior to discharge.*

67. Notwithstanding the guidance, it does not appear that sufficient testing was occurring in NHS Wales. On 9 June 2020, Andrew Goodall observed in an Executive Call that *"looking at testing numbers - not doing a lot of testing in NHS environment! Not testing in hospitals"* (INQ000300091_0036). It is unclear what was done, if anything, to address this concern.

68. The recommendation that all patients should be tested on admission was not enshrined in Welsh Government policy until 15 July 2020 (INQ000275673) at which time the testing strategy mandated testing as follows:

- *Emergency Admissions: all patients will be tested on admission. For patients who test negative, further testing will be undertaken if COVID-19 symptoms are present or develop.*
- *Elective Admissions: when prevalence in the community is high there is merit in providing testing for elective admissions (including day surgery), where patients will be required to self-isolate and pre-admission testing undertaken (conducted a maximum of 72 hours in advance), this will take into account the type of procedure or treatment to be undertaken.*
- *Outpatients / diagnostic interventions: utilise testing and isolation which will be determined, based on patient and procedural risk. When using the test to inform discharge for individuals whose symptoms of COVID-19 have improved, then a negative RT_PCR, taken 14 days after onset and/ or a detectable antibody level is consistent with an absence of infectivity.*
- *Discharge: all patients being discharged to a care home or a hospice will continue to be tested prior to discharge to ensure that they do not transmit the virus into closed settings.*

69. When asked about the delay in the mandating of testing of all emergency admissions until July 2020, Professor White stated *"I think we gave them a run-in time to actually get the systems in place in order to do that consistently. Now, obviously, once the guidance is out there, there will be early adopters but some folk will take a little bit longer to get systems in place. So often we would give them a couple of weeks' time lag to get to a position where everybody was doing it. It's a big system"* [6/121/14-21]. These operational difficulties ought to have been known to the Welsh Government through stakeholder engagement and strategic plans implemented in advance of the announcement to assist NHS Wales in the delivery of

Welsh Government policy. The Welsh Government's approach screams 'laissez faire' at a time when clear direction was required.

70. Finally, it was only in the January 2021 guidance that the Welsh Government first recommended testing of **all** patients on admission (with further testing of asymptomatic in-patients at day 5). The Patient Testing Framework to support the strategy did not follow until 9 March 2021 and it was only in that framework that the Welsh Government recommended a regime of re-testing at 5 day intervals and, in areas with high rates of nosocomial transmission an additional regimen of retesting at 3 and 7 days may be adopted (INQ000081893_0006). No explanation has been given by Welsh Government for this delay. CBFJ Cymru consider this once again to be an example where Wales was painfully slow in circumstances where speed and agility was required.

ESCALATION OF CARE

71. A further area of concern for CBFJ Cymru relates to escalation of care.

72. The powerful impact evidence of Paul Jones, and the distress he and his wife Karen suffered when their daughter Lauren was not escalated until her oxygen levels became dangerously low [INQ000486000/0007] will, no doubt still be with the Inquiry. Anna-Louise Marsh-Rees explained that when her father's oxygen levels dropped dramatically, the hospital could not find a high-flow oxygen machine to support him for 40 minutes by which time she was told "that ship has sailed" [39/14/16-17].

73. It is trite that there had been a long-standing issue in respect of critical care capacity in Wales. A Welsh Government Task and Finish Group on Critical Care report dated July 2019 (INQ000466422) shows that since at least 2014 Wales's Critical Network's critical care capacity was 5.7 beds per 100,000 of the population (compared to 7 in the rest of the UK and the 11.5 average across Europe) and that an additional 73 critical care beds would be required across Wales immediately. Notwithstanding the alarming results of the 2014 study, the 2019 Task and Finish Group reported *little recent change* in the number of beds available for critically ill patients across Wales.

74. Further, Dr Daniele Bryden gave evidence that the intensive care bed-fill rate in Wales was estimated to be at least 95% in 2018 (10% above that recommended for safe and efficient patient care). When asked what impact this would have had when the pandemic struck, Dr Bryden stated: "*So we have a situation where you have inadequate numbers of staff who are able to respond, and you also don't have the facility, the estate in order to take increased numbers of patients, and it does impact in terms of the ability to manage patients within the footprint of an intensive care service. So we know that when there's a high bed occupancy it does impact on how we deliver care to patients.*" [INQ000389244/0023] [17/175/12-17/176/12]

75. Put simply, it is undeniable that Wales's critical care capacity was objectively lacking in resilience at the outset of the pandemic and further, that little was being done to rectify the situation.

76. The Welsh Government and key Welsh witnesses have been at pains to stress that critical care capacity was not breached in Wales, however, the accounts given by the bereaved and those working on the frontline in Wales point toward healthcare workers feeling pressured to make decisions about escalation and access to critical care, patients being turned away from critical care who would otherwise have been admitted to critical care, and gatekeeping access to treatment.

77. Within its oral opening statement, the Welsh Government stated, "*As far as the Government is aware, there were no incidents where a patient who was clinically appropriate to receive critical care was unable to access a critical care bed in the in the relevant health board area or at least from a neighbouring health board area.*" Further, Andrew Goodall asserted in his statement that Wales had beds free through the first and second wave [INQ000485721_0163 paragraph 416) , and that whilst there was some capacity issues in health boards for short periods, he was not aware of any patient who was deemed would clinically benefit from critical care not getting access to a critical care bed or a bed providing enhanced support (INQ000485721_0216 paragraph 537). CBFJ Cymru submits that the Welsh Government's ignorant optimism is misplaced. In his oral evidence, Vaughan Gething accepted that "*The global figure not being breached showed that we had more capacity to surge into*" but it did not mean that all patients got the treatment they required at the time they needed it; "*Whether people got the appropriate treatment is*

actually a matter about what was taking place with and for that person. And even in a time where capacity is not breached it's possible for people not to get the care that they need." He further conceded that, though it was never brought to his attention that people were not getting the critical care they needed "*That doesn't mean it didn't happen"* [35/112/10-11].

78. Vaughan Gething's concession is the only common-sense conclusion to draw from looking at the critical care data available to decision-makers in Wales, which only demonstrated the global figure for critical care beds. Andrew Goodall was questioned at length regarding the adequacy of Welsh data. Put bluntly, CBFJ Cymru considers that the data being used by the Welsh Government was completely deficient for the purpose of any meaningful analysis and informed response. For example, it does not appear that the data differentiated between beds that were theoretical and beds that were functional and ready for use. Asked about the level of granularity of the data available to Welsh Government, Andrew Goodall asserted that the Welsh Government *"would have expected the health boards"* to have data showing which beds are ready to be used, which beds are in surge capacity, which beds are purely theoretical, how many patients are receiving CPAP, how many additional beds are available for patients who need mechanical ventilation etc [31/9/18 – 31/10/11]. This was important data that should have been collated, analysed and held by Welsh Government

79. It is particularly telling that the Chief Information Officer from Cwm Taf Morgannwg ([M2B] INQ000409575_0019) has been critical of the limitations on the data collected by Welsh Government stating: "*The recording of CPAP use was never resolved in Wales. As a result the sitrep reports were never relied upon by anybody undertaking analysis. Rather than addressing the shortcomings, the publishers presented the numbers with a warning on that they included suspected numbers ... The absence of reliable CPAP data meant that we went through the first and second waves unable to evidence our preparations as to whether we had enough CPAP machines and oxygen to meet need ... The lack of data diminished the ability of clinicians to use data to audit and compare the effectiveness of care for Covid patients. Better data would potentially have helped care optimisation or have helped the clinical teams to make changes to how they delivered care earlier."* This account is a damning indictment on how the Welsh Government's poor data collation and analysis impacted on the delivery of care to patients in Wales.

80. The height of the Welsh Government's position, therefore, must be that there was always theoretically a critical care bed available somewhere in Wales during the pandemic. The data does not demonstrate that individual hospitals did not breach capacity, that these critical care beds had available to them the appropriate staffing levels, that the bed was in the right place at the right time, nor does it demonstrate that the bed came with the requisite equipment such as a ventilator. Accordingly, the Welsh Government's statement that as far as they are aware it never breached capacity does not in any way demonstrate that people in Wales received appropriate escalation of care in all circumstances.

81. The Inquiry heard important evidence from Professor Summers and Dr Suntharalingham who opined that variations in decision making and conscious or subconscious application of clinical thresholds are likely to have occurred, and that ICU admission changed via local informal processes meaning those who might ordinarily be admitted to Intensive Care Units were not. They also highlighted that care delivered on the ward was not captured in measures of ICU admissions collated by ICNARC and accordingly the data underestimates number of critically ill patients (INQ000474255_0061) [15/40/19 – 15/41/2]. Further, the evidence of Kathryn Rowan of ICNARC highlighted that from the data "*there is evidence that there were some changes in the characteristics, management and outcome of patients admitted to critical care during the peaks of the pandemic waves when capacity strain was at its greatest*" (INQ000480139_0010 paragraph 7.6). Further, IFF Research (INQ000499523) suggests that of all healthcare professionals ('HCPs') surveyed, over half reported that some patients could not be escalated to the next level of care due to lack of resources and significantly, 1 in 3 HCPs reported that they received instructions from their employer on which groups should not be escalated to the next level of care. Most HCP's reported having to act in ways which conflicted with their values.

82. The patterns observed across the UK were also observed in Wales. The witness statement prepared on behalf of Cardiff and Vale University Health Board (INQ000480136_0024 paragraph 81), noted that very few patients were transferred to other Critical Care Units. The statement notes that unlike in England, Wales's Critical Care Network is not an operational network and although capacity was continually measured and daily conference call meetings took place, formal capacity balancing agreements were less rigid in Wales. The statement notes that at UHW, over capacity events were primarily managed with dilution of nursing ratios rather than patient transfers.

83. This statistical analysis is supported by the anecdotal evidence, not only of the bereaved, but of critical care doctors themselves, one of whom who said: "*We knew it wouldn't help because we had come to see what kind of people died of this disease despite escalated care. So we decided not to admit to critical care whereas had they had a different illness, they probably would have been more likely to benefit so we would have escalated. We didn't have enough space to give people a go who had a very remote chance of getting better. If we had had more capacity, we might have been in a position to try*." (INQ000499523_0022)

84. This evidence plays on the minds of CBFJ Cymru, many of whom had loved ones who died outside of the intensive care unit or respiratory wards. The torturous thought of what might have happened if only their loved one had been ventilated sooner or at all, and the wondering of whether their loved ones would have been able to celebrate this Christmas with them, if only they had had access to care they would otherwise have received in peace time.

85. CBFJ Cymru submit that informal variations in ICU admissions, combined with the data underestimating the overall number of critically ill patients, perpetuated the Welsh Government's myth that critical care was not saturated.

86. Another reason why the admission numbers to critical care units must be treated with caution, is that in Wales, as in other nations, staffing ratios were diluted to avoid breaching capacity and critical care was provided outside of ICU. Professor Summers gave evidence as to the importance of care being delivered on a critical care unit due to staffing ratios and the experience of care providers [19102/3-18]. CBFJ Cymru considers that those patients in Wales who were critically ill but managed out of critical care were put at risk. The risks posed to patients as a result of diluting the staff to patient ratios was acknowledged by Professor Jean White in her oral evidence [6/105/21 – 6/10] which reflects the contemporaneous view expressed to her in an email dated 12 January 2021 where it is stated "*Sorry for the delay in replying on Monday for example, 11 of the 13 ICU units were on a 'stretched nursing ratios 1:2 for level 3 patients'. Redeployed staff have been moved to critical care to help out these units. However, given the whole hospital strain and vast number of patients in critical care, redeployment hasn't actually been 100% enough for all*

critical care patients / units in Wales. Uncertainty around the impact of this on the quality of care and ultimately to the outcomes of the patients." (INQ000412539_0003)

87. Rather than congratulate itself for never breaching critical care capacity, CBFJ Cymru asks the Welsh Government to look behind the data toward the material reality of what hospital looked like for those patients who desperately needed care. The data does not tell the whole story. It does not show the conscious and subconscious decisions made by doctors, the diluted nursing ratios, whether there was sufficient capacity for ventilators, medication, equipment and consumables in the hospital where it was needed at the time it was needed.

88. As Professor Summers and Suntharalingam stated in their evidence, it is the role of national bodies to step into that breach and support not only their members but the wider patients and public in order to provide variation and provide consistency among the four nations, but also to make sure the staff do not have that moral injury of feeling themselves in that position without external support of people that are meant to be representing and protecting them. [19/96/24 – 19/97/7].

DNACPR

89. The evidence heard in Module 3 has highlighted that at the outset of the pandemic unacceptable practices surrounding DNACPR and use of the CFS (and other crude scoring matrices) in the escalation of care were widely reported.

90. On 27 March 2020 a General Practitioner Surgery in Maesteg sent letters to those with life threatening illnesses asking them to complete a DNACPR (INQ000400633). The letter states that they would "*unlikely to be offered hospital admission*" and *"certainly will not be offered a ventilator bed"* if they became unwell with Covid-19. The letter identifies several *"benefits"* to completing a DNACPR including *"1/your GP and more importantly your friends and family will know not to call 999. 2/ scarce ambulance resources can be targeted to the young and fit who have a greater chance"*. The letter states *"we will not abandon you...but we have to be frank and realistic"*. In Module 2B, the Older People's Commissioner for Wales, Helena Herklots described in her written and oral evidence the level of distress caused by the letter and the approach to the elderly more generally. She stated in her oral evidence that issues pertaining to the use of DNACPR, together with a

"number of different things happened which, cumulatively, older people who were talking to me or talking to other older people which was being reported to me, there was certainly feeling that -- that sense of, yeah, just not being valued." [M2B 2/128/7-11].

91. In Wales it was made clear to healthcare professionals through various guidance documents and joint statements (INQ000226990; INQ000235489; INQ000252780; INQ000081000; INQ000300701; INQ000300106; INQ000227432; (INQ000283301) that it is unacceptable for DNACPR forms and Treatment Escalation Plans to be applied to groups of people of any description and that decisions must continue to be made on an individual basis according to need.

92. Notwithstanding guidance having been given to healthcare professionals, unacceptable practices surrounding DNACPR continued throughout the pandemic including medical professionals making decisions at speed without adequate or any discussion with patients and families (INQ000339027); care home managers being under pressure by healthcare professionals to sign wholescale DNACPR instructions on behalf of residents (INQ000319639_20). Striking evidence has been given by the Welsh bereaved of such concerns.

93. Professor Lockey of the Resuscitation Council UK (INQ000343994) gave evidence that DNACPR is intended to guide clinicians in event of cardiac arrest and should not impact on escalation of treatment, but it is often misunderstood by clinicians. In England, the RESPECT process has been introduced to mitigate these concerns and to represent a single comprehensive summary of personalised recommendations for a person's clinical care. There is no such plan to roll out RESPECT in Wales (notwithstanding it is being rolled out in each of the other four nations). Instead, Wales has an All Wales DNACPR Policy and a *"variety of forms"* addressing various aspects of advanced care planning and treatment escalation. Professor Lockey suggests that the absence of a nationally standardised process creates patient risk and recommends that the RESPECT process be adopted in all four nations.

94. The evidence of Anna-Louise Marsh-Rees [39/16/13 – 39/17/14] serves to highlight the patient risk described by Professor Lockey which is inherent in Wales's multi-form system. Ms Marsh-Rees explained:

Most of us were not consulted. And most of us didn't find out there even was one placed until we got hold of the hospital notes and that could be some months, even years, later. And then also the. confusion with the DNACPR and the treatment escalation plan. My dad's are contradictory to each other, the treatment escalation plan says he is eligible for CPR; his DNACPR says he's not. Neither of them are filled in completely, and, you know, we were told by the health board that they had tried to contact us, but that we were having our dinner. How they knew this, we've no idea, but they have subsequently apologised that they did not attempt to consult us on that.

95. In addition to Professor Lockey's recommendation, the Older Person's Commissioner for Wales has called for a review as to how the DNACPR decision process works in Wales and what improvements can be made.

96. The present lack of digitisation of DNACPRs and Treatment Escalation Plans in Wales renders wholescale audit virtually impossible. This perhaps explains (albeit does not justify) why there has been a failure by the Welsh Government to direct a robust audit of DNACPR decisions taken during the pandemic [31/134/1-13]. The lack of digitisation is unacceptable and should be rectified immediately. When asked about whether NHS Wales had started to create an electronic repository of DNACPR decisions, Judith Paget stated *"Work has begun to understand how that might be developed"* [31/131/5-6]. In response, the Chair rightly opined *"you obviously got plenty of evidence that things aren't going right and you need to do something and you've had the recommendation Mr Mills has put to you that that you say has been accepted by the Welsh Government about an electronic repository which might avoid these things happening and make life a great deal better for the families of people upon whom these notices have been put and indeed for the patients themselves. But when Mr Mills asked you what's been done to create it, you said the Welsh Government's accepted it but then you used this expression "Work has begun to understand how that might be developed". That doesn't sound very specific to me"*. CBFJ Cymru agrees that specificity and measurable actions are required.

ACCESS TO GENERAL PRACTITIONER SERVICES

97. Andrew Goodall initially denied any specific difficulties with patients using video consultation services that was rolled out in all GP practices in Wales (INQ000485721_0283 paragraph 738).

98. Many of CBFJ Cymru's members report that GPs were being hard to get hold of and were in fact not offering virtual appointments when they should have been available. Such concerns were widely reported in the press up to as late as September 2021 (INQ000343992_0004). In addition, the Public Services Ombudsman for Wales investigated several issues relating to the GP service in Wales (INQ000472302_0015-16), including a failure to provide virtual appointments for vulnerable individuals, and service failures in lack of face to face appointments.

99. When asked about these difficulties in evidence, Andrew Goodall accepted *"they were issues that we were made aware of"* but deflected responsibility stating *"The operational use of the systems were for every individual GP practices, they were supported by their health boards to implement that. We wanted to make sure that the platform was available at a national level to give that flexibility"* (31/110/5-10). Dr Goodall failed to identify what steps were taken by Welsh Government and NHS Wales to mitigate the issues identified.

100. Further, the Welsh Government failed to conduct a formal impact assessment for digital inclusion and consideration of recommendations on the elderly, disabled, and those with language/digital access issues was not always explicit in the submission of advice (INQ000485721_0288 paragraph 754). Given these considerations had been part of the Wales strategy for digital health set out in 2015 - 5 years before the pandemic – so should have been easily identified and placed front and centre of the advice. Dr Goodall accepted *"they should have, you're right, the previous strategies were there"* (31/111/6-7).

SHIELDING

101. The shielding plans for the United Kingdom were developed by the CMO's of the four nations. The Inquiry has heard evidence that notwithstanding the clear difficulties in identifying those cohorts of patients who should shield, the data systems are still not in place to enable that process to happen swiftly and accurately (Frank Atherton 30 September 2024 page 77). Sir Frank was very vague as to specific actions that the Welsh Government

is taking to strengthen those systems including any steps to align the primary care and secondary care database systems. The Inquiry has heard evidence about 13,000 of the initial 91,000 shielding letters going to the wrong address; errors in respect of categories of individuals added to the list; delays in sending letters to relevant cohorts of patients; and lack of clear guidance being provided, particularly when the Welsh Government's approach to shielding diverged from the rest of the UK in the Summer of 2020. Ms Marsh-Rees also gave evidence of erroneous information being contained within shielding letters. Ms Marsh-Rees's described that her father received a shielding letter in October 2020 which *"arrived the day after my father died that was (a) telling him he didn't need to shield, which seemed completely baffling because obviously he was 85 with comorbidities, but not only that you should only take a PCR test if you had symptoms, but only with these three symptoms, and that it was pointless to do one if you didn't have symptoms, which I -- we know in October 2020 that everyone knew that, you know, you could test positive and be asymptomatic"* (39/9/1-10). To compound these issues, the Welsh Government has not undertaken an assessment of effectiveness of shielding programme (13/83/16-22) in order to identify what lessons could be learned for the future.

COMPASSIONATE CARE AND DIGNITY IN DEATH

102. The evidence gleaned from this Module highlights that many individuals were denied compassionate care and dignity in death.

103. A number of CBFJ Cymru members reported difficulties in seeing and/or communicating with their loved ones in hospitals and the clinicians who were purporting to care for them. Where communication was forthcoming from clinicians, it was not always compassionate in nature. Ms Marsh-Rees described being panicked and distressed, pleading with a clinician to give her father oxygen to which the doctor replied, *"That ship has sailed"*. Ms Marsh-Rees remarked *"**words matter**, the way the words are written, the way that words are said. Things like that are just, you know, it haunts my sister and I. That -- it's just so casual..."* (emphasis added) [39/14/18-21].

104. Many patients spent their final moments on soleless hospital wards in the company of strained and frightened staff; deprived of contact with their loved ones, scared and alone. Ms Marsh-Rees stated:

most of our loved ones…were older. They led very silent, quiet deaths...it's almost death by indifference…nobody communicated to them, nobody told them what was happening, they didn't have communication with their loved ones. And I really do think we need to ponder on…that element of it. It's those quiet silent deaths that are the real tragedy [39/13/8-16]

105. The Inquiry has also heard evidence that the bodies of some individuals were lost temporarily by the morgues, with no apology offered to distraught loved ones and belongings of the deceased, if not already lost, having been presented back to family members in clear plastic bags, often covered in urine or blood, without warning [39/17/23-39/19/2].

106. Finally, the Inquiry has heard evidence that employees in Aneurin Bevan University Health Board (then under the leadership of Judith Paget) were given permission to take photographs of patients, both living and dead, for the purposes of publication. The photographs included photographs of people on ventilators and bodies in body bags. Impacted members of CBFJ Cymru consider that these were highly sensitive images of seriously ill, vulnerable and dying patients and they seriously question the morality of taking photographs and how valid consent could have been reliability obtained in such circumstances. The images have resulted in re-traumatisation for family members who have been left deeply upset and angry that authorisation was given. In the words of Sam Smith-Higgins (INQ000486273_0011 paragraph 30) '*It beggars belief why the health board thought it would be appropriate to permit employees to use the suffering endured in the pandemic…whilst people were dying…'*. The hurt is further compounded by the perceived lack of accountability of decision-makers. As Anna-Louise Marsh-Rees (INQ000343992_0011 paragraph 41) said '*There appears a lack of willingness to accept that this ought not to have happened.'*.

107. Where was the dignity for the deceased? Where was the compassion for the bereaved?

108. In brief: words matter and compassion matters.

RECOMMENDATIONS

Urgent Interim Recommendation

109. The evidence in Module 3 has overwhelmingly supported the need for adequate IPC controls to limit airborne transmission of Covid-19, yet the current guidance still only requires FFP3 masks to be worn when AGPs are performed. The IPC Guidance is *"outdated"* and *"are in urgent need of updating"* [INQ000474276_0087].

110. With this in mind, CBFJ Cymru considers that the Chair should made an interim recommendation for an urgent review and revision of the Infection Prevention Control ('IPC') Guidance to ensure that it reflects the evidence of aerosol transmission and appropriate risk mitigation e.g. FFP3 masks, ventilation and segregation.

Other Recommendations

111. In light of the foregoing, CBFJ Cymru advance the following submissions for the Inquiry's consideration:

- Transparency, honesty and stakeholder engagement on the development and implementation of IPC guidance;

- Welsh Government to ensure that the healthcare system in Wales is adequately resourced on day-to-day and emergency bases;

- Welsh Government and NHS Wales to commission a transparent and independently audited review of the structure of the NHS in Wales with a view to establishing clearer divisions of responsibility between Welsh Government and NHS Wales and defining the leadership role of Welsh Government;

- Welsh Government and NHS Wales to commission a transparent and independently audited review and risk assessment of the condition of the NHS Wales Estate to better support the implementation of Infection Prevention Control measures. In particular, this should include a review of ventilation capabilities and recommendations for the implementation of appropriate ventilation across the NHS Estate including more widespread use of HEPA filters and CO2 testing;

- Welsh Government and NHS Wales to commit to measurable targets for reducing nosocomial transmission generally i.e. by a certain percentage by a particular date. IPC guidance generally to be reviewed to ensure appropriate emphasis is placed on the importance of appropriate PPE and regular staff and patient testing to mitigate against nosocomial transmission;

- Welsh Government and NHS Wales to provide plans setting out how it intends to keep the clinically vulnerable safe when using hospitals;

- Welsh Government and NHS Wales to commission a transparent and independently audited review of critical care capacity in Wales underpinned by a clear methodology for measuring capacity based on factors beyond the physical bed space e.g. availability of suitability qualified staff and availability of medication and equipment;

- Welsh Government and NHS Wales to improve the data infrastructure in Wales to ensure meaningful data collection, analysis and sharing;

- Welsh Government and NHS Wales to formulate a robust pandemic plan with provision for prompt deployment of properly resourced scalable measures in the event of emergency e.g. PPE stockpiles; established supply chains for PPE, testing, medication and equipment; and staffing resilience etc;

- Welsh Government and NHS Wales to establish and effective system for co-ordination across the NHS Wales network;

- Welsh Government to work with the other four nations to strive for alignment and clear public health messaging across the four nations. This should include mechanisms for ensuring that primary and secondary care services are clear in public messaging and advice given to the public;

- Welsh Government and NHS Wales to establish robust systems for consultation between clinicians patients and family;

- NHS Wales to introduce mandatory bereavement support training for all staff;

- Welsh Government and NHS Wales to conduct an audit of DNACPR decisions made during the pandemic;

- Welsh Government and NHS Wales create an electronic repository of DNACPR/Advance Care Planning/Escalation of Care documentation;

- DNACPR/Advance Care Planning/Escalation of Care etc documentation to be accessible via the Welsh Clinical Portal to ensure that relevant documents are linked.

CONCLUSION

112. CBFJ Cymru is grateful to the Inquiry for supporting its ongoing participation in the Inquiry.

113. CBFJ Cymru commends the inclusion by the Inquiry in Module 3 of the oral evidence of representatives of the bereaved family groups. Hearing directly from bereaved family members has been vital to ensuring that the impact of Covid-19 in Wales is fully understood and to ensure that the significance and magnitude of the issues under investigation in the Inquiry are not lost. The bereaved must remain at the heart of this Inquiry.

114. CBFJ Cymru looks forward to receiving the Module 3 report which it hopes will contain constructive and measurable recommendations across the range of issues covered within this written submission.

CRAIG COURT
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20 DECEMBER 2024