COVID 19 INQUIRY

MODULE 5:

PPE AND PROCUREMENT

OPENING SUBMISSIONS

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

Introduction

1. These opening submissions are prepared on behalf of the Covid-19 Bereaved Families for Justice Cymru ("**CBFJC**").

2. The submissions touch on some of the concerns among members of CBFJC in relation to PPE and procurement. These concerns are among those identified in the Inquiry's Final List of Issues (3 February 2025) ("**LoI**").

3. A fundamental concern of CBFJC is that there was not enough appropriate PPE in Wales, both in healthcare and social care settings (particularly care homes). This was the experience of members of the group, their families, and the healthcare workers in their communities. They are told repeatedly by the Welsh Government and its politicians that, on a national level, PPE stocks in Wales never ran out [e.g. witness statement of Mark Drakeford INQ000528293_0007]. But such claims are of little comfort to them and do not alter the fact that there was an appalling shortage at a local level.

4. Members of CBFJC lost family members who contracted Covid-19 in a hospital setting and in a care home setting. Plainly, lives would have been saved had appropriate PPE been made available to those who needed it.

Pandemic stockpiles

5. The Inquiry will be considering whether the stockpiles of key healthcare equipment and supplies were adequate to respond to the Covid-19 pandemic [**LoI 1 §§1-3**].

6. The Welsh Government maintained a stockpile in collaboration with the other UK nations and in accordance (primarily) with the Pandemic Influenza Preparedness Programme (PIPP) prepared in 2011. This meant it maintained a range of medical countermeasures and consumables, such as FFP3 respirators, surgical masks, eye protection, gloves etc. In addition to the stockpile, Wales also had UK wide contracts in place for additional stock to take the PIPP to 15 weeks of supply if required (the 'Just-In-Time' contracts).

7. **The CBFJC submission here is that the Wales stockpile was insufficient.** This cannot be attributed to a UK-wide PIPP strategy which underestimated the demand in the event of a pandemic: the Wales stockpile did not contain that which it was supposed to contain. The stockpile records, exhibited to the witness statement of Andrew Slade (Welsh Government; Director General of Economy, Skills and Natural Resources) show deficiencies in stock, especially FFP3 masks. Crucially, of all FFP3 masks held in Wales as at 6 February 2020 (929,600), over 90% (870,000) were out of date [INQ000300270].

8. It is not clear if, when and how the Welsh Government corrected these issues. FFP3 deficiencies were still an issue by 18 March 2020 (the date of the last stockpile record exhibited by Andrew Slade) [INQ000504943]. By that stage, none of the out-of-date stock FFP3s had been replaced. An emergency 'Just In Time' order had been placed but it is not clear if and/or when the order materialised [INQ000505360]. Audit Wales reported in April 2021 that *"due to a lack of supply in the global market, these 'just-in-time' contracts did not deliver as fully as expected, with none of the FFP3 respirators being received*" [INQ000214235_0013 at §1.3].

9. Andrew Slade states that the stockpile was "*crucial during the first four months of the Covid-19 response and gained time to enable NHS Wales Shared Services Partnership to successfully secure ongoing PPE supplies*" [INQ000506956_0042 at §175].

However, this assurance is hard to reconcile with evident deficiencies in the stockpile And such assurances provide little comfort to members of the group who experienced, firsthand, the devastating effects of a shortage of PPE.

Infection Prevention and Control ("IPC") guidance on FFP3s

10. The Inquiry will consider the operation and effectiveness of guidance in relation to key medical equipment and supplies [**"Outline of Scope" §3; LoI §§4-10: "Structures, systems and processes"**].

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

12. The nature of the IPC guidance in so far as relevant to PPE procurement is summarised in the witness statement of Jonathan Marron [INQ000528391_0063 to _0068] and is not repeated here. In short, the IPC guidance was that from 13 March 2020, FFP3 masks were recommended only for treatment in ICU, or Aerosol Generating Procedures ("**AGPs**"). This guidance was said to be "*based on the reasonable assumption that the transmission characteristics of Covid-19 were similar to those of the 2003 SARS-CoV outbreak, mainly transmitted through respiratory droplets generating by coughing and sneezing, and through contact with contaminated surfaces*" [witness statement of Jonathan Marron INQ000528391_0066 §245; IPC guidance at INQ000325350]. This "reasonable assumption" requires scrutiny, given the large body of evidence pointing to transmission via aerosol (in addition to droplets).

13. Against this background, CBFJC makes three submissions.

14. **First**, there must be serious doubt as to whether the IPC guidance was correct to limit the use of FFP3s to ICU/AGPs scenarios. This is not a question of having the benefit hindsight. This is a question of failing to fully acknowledge the risk at the time the IPC

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

15. **Secondly**, there are serious concerns as to <u>why</u> IPC guidance sought to limit the use of FFP3s, in particular the extent to which IPC guidance was driven by supply/resource constraints, rather than health and safety of health care workers and patients. It is well known that FFP3s cost much more per unit than fluid resistant facial masks (Type IIR masks): in Wales, the average unit price for FFP3 ranged between 10 to 110 times the average unit price of Type IIR masks over the period November 2019 to October 2020.[1] Plainly, the issues with supply and resourcing impacted the IPC guidance:
    a. Professor Jonathan Van Tam acknowledged in an email to the HSE on 23 January 2020 regarding appropriate levels of PPE that, whilst the maximum level RPE was required: "*this was neither affordable nor practical for pandemic stockpiling*" [INQ000151353].
    b. Professor Catherine Noakes explained the reluctance to properly acknowledge airborne transmission, despite a growing evidence base, as (in part) a result of "*the significant resource and operational implications it would have for hospital infection control measures…*" [INQ000236261].

[1] Calculations based on data from NWSSP summarised in report of John Manners-Bell [INQ000474864 at §329; Table 3].

c. Dr Claas Kirchelle explained that cost-cutting considerations "*dominated*" decisions in respect of critical PPE, particularly FFP3s [INQ000205178_0090-92].

d. Specialist Practitioner Laura Imrie, a member of the IPC cell who gave evidence on behalf of Antimicrobial Resistance and Healthcare Associated Infection ("**ARHAI**") Scotland, said that *"If we wrote guidance as a precautionary principle to put everybody into FFP3 then not only would they have had a large amount of the workforce that couldn't comply with the guidance, and therefore couldn't come to work, we would also have had high risk areas...that might have been left without the FFP3s...there was at the beginning of the pandemic a very quick and a rapid stocktake of what stock we held and what was required, and from my understanding that would have made it really difficult to supply the FFP3s to ITU units and other areas we deemed high risk"* [05.11.2024/149:17 – 05.11.2024/150:8].

16. Such concerns were felt on the ground, at local authority level. Chris Llewelyn, Chief Executive of the Welsh Local Government Association ("WLGA") observed in his witness statement that: "*local authorities were uncertain what to purchase and at what scale — it appeared that guidance was driven by what was available on the market rather than by products which were fit for purpose or achieved the conditions to limit the spread and impact of Covid-19*" [INQ000518355_0015 at §33].

17. A briefing note from Chris Jones, DCMO for Wales, dated 13 January 2021 confirmed that "*FFP3 masks are relatively challenging to procure, certainly global production would not be sufficient to meet an increase in demand"* and *"UK IP&C guidance must be followed across the UK and that to allow the wider use of FFP3 masks would not only be inconsistent with the evidence, but also threaten the availability of such items for areas where they are evidence based and effective e.g. ITUs*" [INQ000473726].

18. Thus, CBJFC is concerned that, as far as IPC guidance is concerned, the emerging picture is one of **supply-led guidance, rather than guidance-led supply**. Given guidance determined the procurement strategy, the result is that many healthcare workers in Wales were given a level of PPE insufficient to protect them, and their patients, from the virus.

19. **Thirdly**, the problem of with IPC guidance on PPE is best understood with examples from people's day to day experiences during the pandemic. Two such examples of appear below:

    a. Alan Haigh was an emergency technician for the Welsh Ambulance Service. In February 2021, he attended the patient's home and caught Covid. His colleague, Ms Cadi told an Inquest that the Mr Haigh was wearing level 2 PPE. This comprised masks, gloves and aprons, and was the level of protection issued to staff for routine patients. Ms Cadi herself wore level 3 PPE, as she administered the treatment. Both acted in accordance with guidance. Clearly, Mr Haigh's level of PPE was not sufficient to protect him, and he passed away from Covid.

    b. A locally employed doctor told the BMA "*I was redeployed to ICU [Intensive Care Unit] part way through from AMU [Acute Medicine Unit]. The difference in protection was stark. In ICU we had full PPE for anyone suspected and were told by consultants to take our own PPE to any ward patients to protect ourselves [...] On the AMU side, even though there is an undifferentiated take, self bought masks were not permitted (as they would frighten patients!) until a while after the CDC [Centres for Disease Control and Prevention] and WHO [World Health Organisation] recommendations were made. It was clear that ICU was prioritised and wards were having other 'guidance' to protect PPE levels. This is not equity, and judging by the level of staff COVID sickness in wards compared to ICU, and patient breakouts, there are indicators that staff and patients came to harm during this time due to these differences*" (witness statement of Professor Philip Banfield on behalf of the British Medical Association [INQ000562457_0018] at §58).

The shortage of PPE and nosocomial infections

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

21. CBFJC considers nosocomial transmission of the virus to be one of the principal symptoms of the failure to distribute PPE.

22. It was well known in communities across Wales, particularly as the pandemic went on, that there was a high risk of nosocomial transmission upon admission to hospital. Families felt a grim inevitability that, if admitted to hospital during the pandemic, their loved one would contract Covid. Their fears were well founded: data from Public Health Wales ("**PHW**") showed that, as of 24 February 2021, of the 1002 patients in Welsh hospitals testing positive for covid, 529 of these (53%) were classified as "hospital onset" cases [INQ000227307_0002]. The situation has not improved: PHW data as of 09 February 2025 shows some 83% of inpatient Covid-19 cases in Wales were the result of hospital-acquired infection.

23. Against this background, CBFJC makes two submissions.

24. **First,** notwithstanding the repeated claims that the PPE stocks distributed by the NWSSP never ran out, the reality was that it did; or at least it did not reach those who needed it. Plainly healthcare workers are among those who needed it most.

25. Examples of shortages in a hospital setting from among the **group's members** are too many to note here. The experience of many in Wave 1 was that they would attend hospital to find healthcare workers "with zero to minimal PPE". In Wave 2, members saw healthcare workers generally equipped with surgical masks, gloves and aprons, but no FFP3. By that stage, of course, the nature of aerosol transmission was known, and yet healthcare workers were under-protected. The result was that patients caught covid whilst in hospital.

26. This experience is exemplified by Sam Smith-Higgins, co-leader of CBFJC. She told the Inquiry in her oral evidence [Day 2-15.01.25/115:21-117:22] about her fears for her 73-year-old father, who was admitted to hospital in early January 2021 for cancer related treatment and was immune suppressed and vulnerable. He was not permitted access to a high efficiency particulate arresting ("**HEPA**") filter (even though Ms Smith Higgins offered to source one herself) and nor was he ever offered a mask. Tragically, just three weeks after being admitted to hospital, he died from a Covid-19 infection acquired in hospital. Another member of CBFJC, Cath Griffiths, described her experience in this way: *On 16th November, I was invited to the home to say 'goodbye' to Dad. I wanted to go in and be by his side and to hold and comfort Dad; my brother*

urged me not to. The level of PPE in the home was abysmal; we could see the nurse wearing just an apron and a flimsy surgical mask. I was forced to say goodbye to my father whilst standing in the icy rain, outside his window." (statement to be disclosed in Module 6).

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

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

29. **Secondly**, the importance of adequate ventilation in hospitals in controlling nosocomial transmission is obvious yet went unaddressed. CBFJC reminds the Inquiry of the evidence of Dr Shin Module 3 that there was insufficient consideration given to ventilation beyond the opening of windows. Dr Shin in his oral evidence recommended common-sense alternatives to installing new ventilation, namely UV filtration system and HEPA filters [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 CBFJC, HEPA filters are a valuable piece of

equipment which could have reduced nosocomial transmission rates and potentially saved lives.

PPE in care homes in Wales

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

31. The supply of PPE to care homes is a particular concern for the members of CBFJC, a number of whom lost loved ones in care homes during the pandemic. The Inquiry will recall the alarming evidence of Mr Drakeford, First Minister for Wales in Module 2B: "*There is no single register of where every care home in Wales is located*" [M2B/Day 11-13.03.24/211:15-16], which begs the question, how was supply to PPE to be managed and monitored among this most vulnerable priority group in Wales, when the Welsh Government didn't even know of their existence?

32. By way of context, the number of deaths in care homes in Wales increased by an average of 28% from 2019 to 2020.[2] The increase was particularly marked in the most disadvantaged communities in Wales: an average increase of 51% , for example, in the Valleys (Merthyr Tydfil (85%), Caerphilly (59%), Rhondda Cynon Taf (49%), Blaenau Gwent (35%) and Torfaen (27%). Not all those deaths were, of course, related to Covid-19. Nor can the proportion of deaths directly attributable to issues with supply and distribution of PPE be quantified. But it is obvious that an adequate supply of appropriate PPE to care homes would have prevented infections and reduced the death toll.

33. Against this background, CBFJC raises four points designed to highlight just some of the problems of PPE supply in care homes in Wales.

34. **First**, CBFJC is concerned about the delay in providing PPE to care homes. The likely need to deliver PPE to social care settings was recognised as early as 18 February 2020

[2] Office for National Statistics "Deaths in Local Authority and Non-Local Authority care homes, by Local Authority, 2010 to 2023, England and Wales" .

[INQ000470674]. Yet it was not until 19 March 2020 that the remit of the NWSSP was extended to procure and supply care homes. Those operating at a local authority level felt that the Welsh Government failed to recognise the needs of the social care settings, as it prioritised supply of PPE for the NHS [CL/WLGA statement INQ000518355_0009 at §19 and §21].

35. **Secondly**, shortages in supply persisted well after the official announcement that NWSSP had taken procurement and supply to social care (19 March 2020). During the first few months of Covid, and notwithstanding the expanded role of the NWSSP on 19 March 2020, councils were seeking supplies of PPE from the NHS, but such supplies were dependent on a positive case being identified, and in any event the nature and timing of provision from NHS stock was unknown. Local authorities had to forecast demand, place their own orders and chase supply [INQ000518355_0010 at §§20-22]. It was not until much later – September 2020 – that a Service Level Agreement between the NWSSP and the WLGA was reached [INQ000518355_0010 at §§29-30; 43], an agreement only formalised in a letter to social care providers on 12 October 2020. By that stage, of course, Wave 2 of the pandemic was already underway. Whilst it is reported that NWSSP did not run out of stock, the WLGA has noted that was not the case for the care sector, which reported an inability to obtain stock at points throughout the pandemic [INQ00518355_0020 §§46-47].

36. **Thirdly**, there were shortcomings in the level of protection in care homes. The packs initially prepared – and distributed to local authorities for onward distribution to care homes– contained a fluid resistant surgical mask, apron, gloves and eye protection [16 March 2020; INQ000470675]. These items continued to comprise the stock made available to care homes via their local authorities throughout the pandemic (as shown by data from Stockwatch, the electronic stock management system) [INQ000436116]. Yet, as set out above (§§10-19), FFP3 masks (absent in the packs) were essential in preventing the spread of aerosol transmission.

37. **Fourthly**, the guidance for care home workers on the use of PPE was inadequate.

38. PPE guidance for care homes was based on UK/national level guidance. It therefore suffered from the same failings as nationally agreed IPC guidance (§§ above). The

effect of the failure to recognise the asymptomatic nature of the virus, and its airborne transmission, was particularly marked in care homes. The Minister for Health and Social Care, Vaughan Gething, announced on 16 March 2020 stated that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. A letter to social care providers on 18 March 2020 following Mr Gething's announcement confirmed (i) PPE was for those directly caring for confirmed or suspected case, and (ii) that higher level of PPE was "unlikely to be needed" in a social care setting – such equipment only being needed by those undertaking AGPs [INQ000470681]. We note that the most recent PHW IPC guidance for Acute Respiratory Infections ("ARIs") in Wales (2024-2025)[3] recommends that social care staff use "*FRSM (type IIR) when working in respiratory care pathways and when clinically caring for suspected/confirmed COVID-19 and Flu patients*" (p.8/17) and only recommends FFP3 masks "*if an unacceptable risk of transmission remains following the hierarchy of controls*" (p.15/17). It is not known how those in care homes – a "high risk setting" because they cannot mitigate risk with a hierarchy of controls (p.6/17) - are expected to conclude there is "unacceptable risk following the hierarchy of control", such that FFP3s are required. It seems therefore that current guidance for care homes does little to correct deficiencies in earlier guidance.

39. Further, PPE guidance for social care settings was said to be adapted by Public Health Wales to a social care setting [witness statement of AS at INQ000506956_0068 at §287]. However, in the opinion of those working in the sector (who were already disadvantaged by the lower levels of training in PPE use as compared to NHS staff) the guidance was poorly adapted. Chris Llewelyn, Chief Executive of the WLGA summarised the problem as follows: "*Guidance, where available, was predicated on NHS applications and did not easily translate into non-hospital care settings...it was also not clear about the specific application of PPE required in different situations*" [INQ000518355_009 §19; §34]. The lack of clarity had a knock-on effect on supply: the guidance left room for interpretation, and as such affected usage, and in turn, hampered the ability to accurately predict demand for PPE in the care sector [INQ000518355_017 §36].

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

Procurement

40. The Inquiry will be considering which systems and tools were in place for procuring key health care equipment and supplies [**LoI 2 §4; §6**]. Consideration will also be given to the VIP Lane [**LoI 3**].

41. It is widely reported that Wales did not establish a "VIP lane". However, also widely reported is the lack of competitive tendering to source PPE and the high prices paid for the PPE that was ultimately bought. The CBJFC welcomes exploration of these important issues in Wales – notwithstanding the absence of a VIP Lane.

Covid-19 Bereaved Families for Justice Cymru

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