Module 6 of the UK Covid-19 Inquiry

Written opening statement on behalf of the Covid-19 Bereaved Families for Justice Cymru

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Introduction

1. At the outset of this statement, Covid-19 Bereaved Families for Justice Cymru (CBFJC) wish to emphasise the critical importance of this module for its members, many of whom lost their loved ones while they were resident in a care home.

2. The group's members are horrified at just how dangerous these settings were during the pandemic, including:

    i. there were some 1,400 excess deaths in care homes in 2020 compared to 2019 (from a total population of only approximately 25,000 residents); and
    ii. case fatality rates were as high as 35.7% [INQ000544928_0001] and 33% of surviving residents were found to have been infected in 2020 [INQ000544930_0001].

3. Residents of care homes in Wales were the people most vulnerable to infection, and yet they were locked down and isolated within the least safe environments in the country.

4. The Welsh Government failed in its duty of care towards its citizens in the following ways:

    i. Failures of preparation and to learn lessons for improvement, including between waves 1 and 2.
    ii. A failure to implement necessary testing regimes to control known high levels of nosocomial transmission.
    iii. A failure to adopt a precautionary approach, in particular to the known risks of aerosol and asymptomatic transmission.
    iv. A failure to ensure adequate IPC within care homes, including appropriate PPE and ventilation.
    v. The suspension of vaccinations of care home residents at the height of wave 2.

5. Elderly people were also de-prioritised, and their care and treatment compromised because of a lack of appropriate medical treatment, medicines,

and equipment, examples of which include:

i. Their discharge into residential care, inappropriately, and while in need of hospital in-patient care and treatment, often while infected with Covid-19.
ii. Refusal of admission to hospital for necessary care and treatment.
iii. Death while alone and while experiencing unnecessary pain and suffering because of the lack of availability of appropriate medicines and equipment.

6. Through its participation in Module 6 the CBFJC wishes to assist the Inquiry in understanding how this catastrophe was allowed to happen, and to ensure that it never occurs again.

Deaths and rates of infection in care homes in Wales

7. When assessing the numbers of deaths the group asks the Inquiry to take account of the following evidence that supports the fact that large numbers of Covid-19 deaths were not recorded:

i. many deaths of care home residents in Wales were not diagnosed or recorded as caused by Covid-19 because of the lack of available testing, as confirmed by Professor Shallcross, whose published report on mortality in UK care homes states that, "*UK statistics suggest that two-thirds of excess deaths recorded in residents in the last 6 months involved COVID-19, but this is likely to be an underestimate because many residents were not tested*" (INQ000544928_0002].
ii. many elderly people with Covid-19 did not exhibit the common symptoms of Covid-19, with the only symptom often acute confusion, as Professor Tim Spector told the Inquiry in Module 7.
iii. The witness statement of Helen Hough [INQ000587639], a care home owner and member of CBFJC, who confirms that none of the patients in her care home who died with symptoms of Covid-19 before 20 May 2020, were tested, and that consequently their deaths were not classified as Covid-19 deaths. Ms Hough explains that if a resident required testing, the care home first had to ring the GP and then Public Health Wales to book a test. It then took a minimum of 48 hours from ordering a test to receive the swab that would enable a patient to be tested, by which time many of their residents had sadly died. Twelve patients in Ms Hough's care home died before the Welsh Government commenced routine testing in care homes in May 2020.

8. In these circumstances, the CBFJC group considers it a reasonable assumption

to attribute all excess deaths within care homes in waves one and two as Covid-19 related deaths and this statement is premised on this basis.

9. The Technical Advisory Group (TAG) in Wales produced a publicly available report, 'Examining Deaths in Wales Associated with COVID-19' dated 30 March 2022 which (at pages 4 and 5) identifies a 12% increase in excess deaths in Wales in all settings in 2020, against a five-year average, and that in 2021 there was an 8% increase.

10. Further, these annual increases were much higher within waves 1 and 2: in wave 1 (March to June 2020) the increase in excess deaths was 21.5%; and in the second wave (October 2020 to March 2021) the increase was 17.9%. The report also identifies the peak for excess deaths in wave 1 as mid-April 2020, and January 2021 for wave 2.

11. Terrible though this data is for the population of Wales as a whole, it was even worse in care homes. Deaths in care homes in Wales increased from 5,454 in 2019 to 6,877 in 2020, an increase of 1,423 or 26% (more than double the increase in the general population).

12. In April 2020 (the peak of the first wave) deaths in care homes in Wales more than doubled from the previous month - increasing from 596 deaths in March 2020 to 1,231 in April 2020.

13. And during the peak of the second wave (when testing was more widely available, allowing more cases of Covid-19 to be diagnosed) some 417 Covid-19 related deaths of care home residents were recorded in January 2021, out of a total of 909 (as reported to Care Inspectorate Wales (CIW) [INQ000198645]).

14. The individual experiences of CBFJC group members echo the national picture. One member of the group lost her father in circumstances that 50% of the residents in his care home (26 out of 52) died from Covid-19. Another member whose parents were resident in separate care homes, lost them both within five days of each other from Covid-19.

15. Other publicly reported examples include a care home in Llanelli that managed to stay virus free until the second wave when 24 residents were infected with Covid-19, and seven died (which broadly supports the case fatality rate of 35.7% at paragraph 2(ii) above). And a care home in Newport of approximately 70 residents that experienced 15 deaths in a month (only two of which were certified as caused by Covid-19 despite 14 of the residents exhibiting symptoms) and in the context of one or two deaths in a normal month.

Lack of preparation and failures to learn lessons

16. These appalling circumstances in which so many vulnerable people lost their lives is a direct consequence of the lack of preparation and capacity within the health and social care system in Wales, in particular:

    i. A lack of hospital capacity;
    ii. A lack of testing capacity;
    iii. Insufficient quantities and types of PPE.

17. Despite the size of the social care sector and the increased vulnerability of care home residents to infectious diseases, the UK's pandemic planning exercises gave almost no consideration to this vital element of preparedness. Shockingly, many of the planning exercises do not even mention social care at all.

18. When planning exercises did mention social care, this was often in the context of business continuity, staff absences and the role of social care in releasing hospital bed capacity. Not a single exercise gave consideration to the particular circumstances and vulnerabilities of care home residents, nor the measures that would be needed to ensure these individuals would be adequately protected in the event of a pandemic.

19. Importantly, several planning exercises (e.g. Taliesin 2009, Cygnus 2016) highlighted the need for future exercises to consider the specific challenges related to social care. The report of Exercise Cygnus, for example, states that "*feedback from both exercises [Cygnus and Cygnet] indicated that further planning was required in order to operationalise current thoughts about how the social care system might cope during a pandemic*". Yet, tragically, it appears these preparations were never undertaken.

20. During the pandemic deaths were not properly certified, post-mortems were not performed, and inquests were not held. This despite care home residents being denied appropriate medical care and treatment because they were inappropriately discharged to care homes, and/or refused access to hospitals, and in circumstances where their safety was compromised by inadequate IPC, PPE, and a failure to test.

21. Nor has there been any other meaningful investigation of the appalling circumstances in which so many elderly people were left to die. The CBFJC has campaigned extensively in Wales for an investigation of nosocomial infections from Covid-19, and in April 2022 the National Nosocomial COVID-19 Programme was established. The Programme has now published a report[1] of its work, which the group had understood would include an investigation of a total of 18,360 cases of nosocomial COVID-19.

[1] www.nhs.wales/sa/national-nosocomial-covid-19-programme/

22. At just 24 pages, the report contains only a small number of general observations and displays no real commitment to understand what went wrong, learn lessons to avoid any repeat, and to provide the families of those who tragically died with much needed answers.

23. Despite its brevity, however, the report does contain some information of relevance to Module 6, including the following passage at paragraph 5.3.2:

> *"Due to the testing capacity challenges early in the pandemic, patients were discharged into other care settings or their own homes without the ability to rapidly test for COVID-19. This was in line with national guidance at the time, which did not advise that negative tests were required before transfer/admission into residential settings.*
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> *Further UK guidance, especially early in the pandemic, actively encouraged the discharge of patients from hospitals into care home settings, to free up hospital capacity in order to manage the anticipated demand for services."*

24. The CBFJC group considers it essential that every death from a nosocomial Covid-19 infection is fully investigated, and given the failures of the Welsh Government to do so (some five years on from the pandemic) the group asks the Inquiry to make this a recommendation of the Module 6 report.

25. A concern related to the lack of investigation into the circumstances of deaths within care homes, is that CIW suspended their inspections, and so care homes were effectively operating unregulated and unchecked for the initial months of the pandemic. Further, and connected to preparedness and learning lessons, it is the view of the CBFJC group that a more comprehensive programme of inspections is required to ensure that proper processes and procedures are in place so that care homes are better equipped to deal with the next pandemic.

26. The care sector in Wales was woefully unprepared for the impact of the pandemic. Over 90% of care facilities are either privately run or run by a charitable trust. The majority of these are small or medium sized enterprises, often operating on very tight margins and as such, most staff are paid low wages. These low wages consequently mean that the sector struggles to retain staff, especially during a pandemic where the risk of exposure to illness is heightened. Staff on a minimum wage, and with no paid sick leave, also have little choice but to work when unwell, further increasing the risk to vulnerable residents.

Testing failures

27. Over 1,000 patients were discharged from hospital into care homes in Wales, prior to the introduction of testing on discharge on 29 April 2020, which seeded infections into vulnerable communities, with devastating consequences, exacerbated by the lack of PPE, the lack of testing (for residents and for care home staff), and the lack of effective treatment and equipment.

28. The extent of this practice goes beyond the failure to identify asymptomatic infections and includes knowingly transferring patients, who had either tested positive or were suspected to be infected with Covid-19, into care homes, which raises ethical issues.

29. Examples include:

    i. The circumstances explained by the CBFJC impact witness, Alison Sibley [INQ000614374], whose mother, Rosalind Brockbank, was admitted to hospital on 4 March 2020 following a fall, and while there acquired and tested positive for Covid-19. Despite continuing to exhibit symptoms of Covid, and a physiotherapist recording in her medical notes that she was **not** fit for discharge, she was nevertheless transferred to a residential care home without a further test. She died on 17 April 2020 after 11 days of deterioration following her discharge from hospital.
    ii. An email exchange between the Association of Directors of Social Services Cymru and Swansea Council on 14 April 2020 [INQ000511731]: "*Swansea have experienced: 1) Discharge to dom care where we weren't informed that patient had been tested. Subsequent result of test was positive. Was back before we had much of a grip on PPE. Risked infection of a number of staff and other care recipients. 8 staff ended up in isolation. 2) Patient discharged to a care home. Were tested as positive. Not symptomatic. Care home weren't aware until after the individual died and GP turned up in space suit saying that they could see on the records that the individual was positive for covid infection…Having a meeting about the ethics of knowingly transferring infection into a care home setting later this week*."
    iii. Email correspondence between Care Forum Wales and the Welsh Government on 2 March 2020 proposing to, "*facilitate faster discharge from hospital and the use of care home beds to free up space in our hospitals…*" [INQ000183761].
    iv. Concerns expressed by CIW to the Welsh Government on 8 April 2020 in relation to proposed guidance advising and encouraging care home to accept patients from hospital including those that might have Covid-19 whether symptomatic or asymptomatic, and

querying how care homes could safely care for patients with Covid-19 and protect the other people living in the home [INQ000198288].

30. Incredibly, this practice of transferring Covid-19 positive patients into care homes persisted into wave 2 in Wales, with patients judged to be 'non-infectious' being discharged from hospital without a negative test from December 2020. Given the huge increase in deaths in care homes during wave 1, this decision demonstrates reckless disregard to learn lessons, to recognise the risks for vulnerable care home residents, and to avoid the huge loss of life experienced in the second wave.

31. In respect of routine testing, the Welsh Government refused to accept the need for routine testing in care homes to combat widespread asymptomatic transmission despite a wealth of published scientific evidence by the end of March/early April 2020 that significant asymptomatic transmission was occurring (to which care home residents were particularly susceptible and vulnerable).

32. To highlight just how slow Wales was to respond to this known risk, in England routine testing on discharge from hospitals was introduced on 15 April 2020 (two weeks earlier than in Wales) and routine testing was introduced for care home residents and staff in England on 28 April 2020 (almost three weeks before Wales, which delayed until 16 May).

33. Meanwhile in Wales the government tied itself in knots trying to justify its lack of action. On 29 April 2020, the former first Minister, Mark Drakeford, told the Senedd that routine tests were not offered in care homes because "*the clinical evidence tells us that there is* ***no value*** *in doing so.*" His own head of science, Robert Hoyle, wondered what "*the rationale, evidence and advice*" was, behind this comment. And on 6 May 2020 (despite having seen incontrovertible evidence of the need for asymptomatic testing within care homes within Ministerial Advice dated 30 April 2020), Mr Drakeford doubled down and repeated in the Senedd, "*I have not seen any clinical evidence that led me to believe that testing of non-symptomatic residents and staff in care homes where there is no coronavirus in circulation had a clinical value.*"

34. On 16 May 2020, the Welsh Government finally changed its position (as mentioned, almost three weeks after England) and introduced some routine testing. However, this was confined to large care homes and only expanded to all care homes on 15 June 2020. Given the majority of care homes in Wales are small to medium sized, this further compounded the already unacceptable delay in testing.

35. The Welsh Government claims that this change of approach could not have been taken prior to 12 May 2020 when 'new' advice was provided by SAGE.

36. This claim is not correct. The UK government had accepted the need for asymptomatic testing from 14 April 2020, and SAGE repeatedly advised from this date of the need for increased testing in care homes. Further, CIW advised in emails to the Welsh Government on 24 April 2020 that "*all staff (and residents in care homes) should be tested whether they are symptomatic or not and in truth these tests need to be repeated at regular intervals*" [INQ000396515].

37. The CBFJC group believes that the real reason that the Welsh Government resisted asymptomatic testing in care homes was because of a lack of testing capacity and because of concerns that such testing would require large numbers of staff to isolate leading to staff shortages (for which the Welsh Government bore responsibility). Blaming scientific uncertainty was simply a convenient means of avoiding this responsibility.

38. It was blindingly obvious to those on the frontline from early in the pandemic that routine testing was needed in order to prevent and control transmission in care homes and the Inquiry will hear in the first week of the Module 6 hearings from Helen Hough, the owner of a care home in North Wales who repeatedly warned the Welsh Government of the dangers of not doing so.

39. For example, in an email that Ms Hough sent to her assembly member and the Minister for Rural Affairs and North Wales on 1 May 2020 - with the specific request that her email be shared with Mark Drakeford and Vaughan Gething - she wrote;

> "*In reality, residents are dying without being tested (it can take 48 hours for PHW to arrange with the LHB for this to take place), the evidence in Care Homes is showing that residents are asymptomatic and then can become very ill for just 24-36 hours before they die, therefore they are not being tested at all before they die, and so the figures in Welsh Care Homes are nowhere near accurate.*
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> *…*
>
> *The staff at the home all have families, and I am sure you would want to know if you were risking taking this dreadful disease back to your families, but without anyone being tested, we do not know who has it, and who does not, so the risk of transmission is exceptionally high, especially as we are discovering with this very new disease that people can be asymptomatic but still test positive, therefore we do not know who is carrying this into the building, and that is why COVID-19 is 'spreading like wild fire' in Care Homes*
>
> *…*
>
> *I do not know how long it is going to be before relatives of the deceased speak to one another and realise they are not being treated with the same importance as England (less than 9 miles from here) and*

as the Prime Minister of the UK want them to be treated. Relatives are assuming these tests are being carried out as they see it on their national news… and [would] be horrified to learn that the Welsh Government has decided it's not important enough" [INQ000598470].

40. In the context of severely limited testing capacity, with just 500 tests available across the whole of Wales in mid-March, and only 15 tests per day available to Welsh local authorities with which to test their social care staff [INQ000569773_0092], CBFJC asks the Inquiry to pay careful attention to the evidence of the Welsh Government that the reason they did not introduce routine testing in care homes sooner than 16 May 2020 was because they reasonably believed that it had no clinical value. As already stated, the CBFJC group believes that the real reasons were a lack of capacity and concerns about the impact on staffing levels, both of which were the responsibility of the Welsh Government and for which 'the science' became a convenient scapegoat.

41. Further, even what little testing was available during the first wave was chaotically administered. For example, this feedback of CIW following a meeting with the Welsh Government on 22 April 2020, reflects that there was: "*no central lead for testing - no one could answer the question who/what organisation is in charge of the testing arrangements. There are disparate approaches in different areas*" [INQ000198307_0001].

Failure to take a precautionary approach

42. In Module 7, the Inquiry heard expert evidence about when the scientific community acknowledged asymptomatic transmission. Professor Fraser told the Inquiry that the evidence of asymptomatic transmission "*emerged quite clearly throughout February and March 2020*" [Module 7, Day 4 Transcript 199/19]. Sir Paul Nurse told the Inquiry there was "*ample evidence, actually from very early on*" of asymptomatic transfer, citing studies from China, Hong Kong, Italy, the cruise ship Diamond Princess [Module 7, Day 4 Transcript 32/11].

43. Professor Harries said that Public Health England was aware of research from the Centre for Disease Control at the start of April that provided strong evidence of high levels of asymptomatic transmission in care homes, and referred to Public Health England's own study of transmission in six care homes in England produced in mid-April that confirmed the same [Module 7, Day 10 Transcript 142/8-18]. Both these studies were reported to the former Minister for Health and First Minister of Wales within a Ministerial Advice of 30 April 2020 and yet no action was taken in response to the clear risks of asymptomatic transmission in care homes, and incredibly the First Minister continued to deny that asymptomatic testing had clinical value.

44. On 14 April 2020, the 'Go Science' advice confirmed that asymptomatic infection represents a large proportion of transmission. This was the same date that Sir Paul Nurse and fellow scientists at the Crick wrote to Mr Hancock to urge asymptomatic testing of health care workers – a priority cohort given their potential exposure to the virus and given their proximity to vulnerable people. Mr Hancock told the Inquiry that that was also the date, 14 April 2020, from which the UK Government started making testing decisions on the basis of asymptomatic transmission [Module 7, Day 8 Transcript 32/23].

45. As already set out, the Welsh Government continued to deny - for another month - that testing in care homes was required in response to the risk of asymptomatic transmission. The view of CBFJC is that recognition of this risk by the UK Government (by 14 April 2020) could and should have been sooner but that by refusing to acknowledge the risk for a further month, the Welsh Government wilfully ignored the evidence, and their failure to act caused unnecessary infections and deaths.

46. The issue of airborne transmission has already received extensive consideration by the Inquiry. In short, CBFJC's position is that airborne or aerosol transmission of Covid-19 is a significant route of infection and should have been recognised as such from the very outset of the pandemic in accordance with a precautionary approach.

47. However, the advice of Public Health Wales to the Welsh Government on 24 March 2020 was as follows:

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

48. These inadequate measures remained in place throughout the pandemic with Public Health Wales reporting to the Welsh Government in December 2021 the view of the UK IPC Cell that "*the IPC guidance as it stands was currently fit for purpose. There was no evidence that the mode of transmission of the virus had changed*" [INQ000252535_0002].

49. The failure to recognise that airborne transmission was a significant route of transmission, to recommend the use of Respiratory Protective Equipment, and to provide this protection undoubtedly contributed to high levels of nosocomial infection and deaths within care homes.

50. The lack of awareness of the dual risks of asymptomatic and airborne transmission and the absence of a precautionary approach is evident within the announcement of the Minister for Health and Social Care, Vaughan Gething, on 16 March 2020 that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. And within a letter to social care providers on 18 March 2020, following Mr Gething's announcement, that confirmed (i) PPE was for those directly caring for confirmed or suspected cases, and (ii) higher level of PPE was "*unlikely to be needed*" in a social care setting - such equipment only being needed by those undertaking AGPs [INQ000470681].

Inadequate IPC and PPE

51. The Welsh Government became responsible for the provision of PPE to care homes on 19 March 2020, and guidance was issued to care homes in Wales on this date that PPE was to be worn by social care staff when providing direct personal care to symptomatic patients. However, despite this guidance and responsibility, some care homes in Wales received no PPE until the end of April or early May 2021, which came too late to prevent widespread infection and death.

52. The narrative from the Welsh Government is that the social care system never ran out of stock. However, the evidence before the Inquiry is that those in care homes did not have the quantities and types of PPE they needed.

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

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

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

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

55. These statements from Ms Herklots and Dr Llewelyn are consistent with the experiences of the members of the CBFJC group. Catherine Griffiths' tragic experience epitomises this. Her father contracted Covid in his care home in Aberystwyth. She describes in her witness statement the last time she saw him:

> *"On 16th November 2020, I was invited to the home to say 'goodbye' to Dad. I wanted to go in and be by his side and to hold and comfort Dad; my brother urged me not to. The level of PPE in the home was abysmal; we could see the nurse wearing just an apron and a flimsy surgical mask"* [INQ000474759_0020].

56. The former First Minister, Mr Drakeford has made statements that at no time was the Welsh system unable to supply the individual components necessary for effective protection. However, relevant to this issue, Mr Drakeford conceded in Module 2B that there was no single register of the location of every care home in Wales, which begs the question how the Welsh Government was able to ensure the supply of necessary PPE to care homes, when the extent of their existence and operation in Wales was not known.

57. Despite recognition by the Welsh Government of the need to provide PPE to care homes as early as 18 February 2020 [INQ000470674], it was not until 19 March 2020 that the remit of the NHS Wales Shared Services Partnership (NWSSP) was extended to procure and supply care homes. And those operating at a local authority level felt that the Welsh Government failed to recognise the needs of social care settings, as it prioritised supply of PPE for the NHS [INQ000518355_0009 at §19 and §21].

58. During the first few months of Covid, and notwithstanding the expanded role of the NWSSP on 19 March 2020, councils were seeking supplies of PPE from the NHS, but such supplies were dependent on a positive case being identified, and in any event the nature and timing of provision from NHS stock was unknown. Local authorities had to forecast demand, place their own orders and chase supply [INQ000518355_0010 at §§20-22]. By May 2020 only two thirds had their PPE needs meet by NWSSP.

59. There were also shortcomings in the level of PPE protection in care homes. The NWSSP packs prepared and distributed to local authorities for onward distribution to care homes contained a fluid resistant surgical mask, apron,

gloves and eye protection [INQ000470675]. These items continued to comprise the stock made available to care homes via their local authorities throughout the pandemic (as shown by data from Stock Watch, the electronic stock management system) [INQ000436116]. Yet, FFP3 masks - absent in the packs - were essential for preventing the spread of Covid-19 by aerosol transmission.

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

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

61. CBFJC notes that the most recent PHW IPC guidance for Acute Respiratory Infections in Wales (2024-2025)[2] 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).

62. It is not understood 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 an "*unacceptable risk following the hierarchy of control*", such that FFP3s are required, and it seems that the current guidance for care homes does little to correct the deficiencies of previous guidance.

63. Concerning ventilation (including in the context of the hierarchy of controls) the UK-wide technical report authored by the CMOs and DCMOs highlights that air quality in care homes is not currently well understood, but that it is key to mitigating the impacts of acute respiratory infections including future pandemics [INQ000203933_0303].

64. However, the physical infrastructure of the vast majority of adult social care in Wales requires very significant retrofitting or rebuilding in order to improve air quality.

65. Further, unless and until these improvements are made, there can be no meaningful application of a hierarchy of controls within care homes, which

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

makes the continued deficiencies in the IPC guidance and failures to provide appropriate PPE and RPE all the more indefensible.

Suspension of vaccinations in care homes

66. A major concern of the CBFJC group at the Inquiry is the decision of the Welsh Government to intentionally delay and stagger the provision of vaccines to care home residents, contrary to the advice of the Joint Committee on Vaccines and Immunisation. The group has already addressed this issue within its closing statement to Module 4.

67. Evidence within Module 6 further demonstrates what an irresponsible and indefensible decision this was, including:

    i. A paper published on 11 March 2021 in the Oxford University Press, 'COVID-19 infection and attributable mortality in UK care homes... (March-June 2020)' (exhibited to the witness statement of Professor Shallcross at INQ000544928) explains that from a cohort of 607 residents with confirmed infections, 217 died, giving a case fatality rate of 35.7%.

    ii. A separate paper published in the Lancet in July 2022, 'Duration of vaccine effectiveness against SARS-CoV-2 infection, hospitalisation, and death in residents and staff of long-term care facilities in England (VIVALDI): a prospective cohort study' (also exhibited to the witness statement Professor Shallcross at INQ000544935) records that vaccine effectiveness for care home residents against death from Covid-19 is established at between 64% and 96% for doses one and two, rising to 97.5% after dose three [INQ000544935 _0007].

68. Given that the fatality rate for an unvaccinated care home resident may have been as high as 35.7% and that the benefits of vaccination were so significant and pronounced, it beggars belief that any responsible government should have sought to delay their provision for operational reasons, as the Welsh Government did.

69. The group also observes that notification of confirmed cases in staff and residents of care homes peaked in January 2021 (Update on COVID-19 Nosocomial Transmission Group and current priorities - INQ000227307/3), with Wales experiencing 417 confirmed Covid-19 related deaths of residents in January 2021 alone, and at times as many as 20 deaths a day.

70. Vaughan Gething, the former Minister for Health and Social Services decided on 25 November 2020 that the Pfizer vaccine would not be used in care homes for the first 4 weeks of delivery (paragraph 95 of the witness statement of

Vaughan Gething [INQ000493687_0023]).

71. This decision was taken following Ministerial Advice to the Minister for Health and Social Services (copied to the First Minister, at that time Mark Drakeford) [INQ000361639], that included the following information:

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

72. Vaccinations in Wales commenced on 8 December 2020, but because of the intentional delay in its provision to priority cohort 1 residents of care homes (contrary to JCVI advice) by 26 January 2021, only 67% of care home residents in Wales had been vaccinated (confirmed in an oral statement of the Welsh Government by Vaughan Gething on this date [INQ0004928860]). And by 16 February 2021, well over two months after vaccination commenced, only 82% of care home residents in Wales had been vaccinated (as set out in the Welsh Government's Vaccinations Update [INQ000410143]).

73. This departure from JCVI advice by the Welsh Government was also noted in Cabinet Office Meeting minutes of 12 January 2021 [INQ000088889], that read:

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

74. The importance of adhering to the JCVI priority cohorts, was explained by Professor Wei Shen Lim in his evidence during the Module 4 hearings [23 January 2025, Day 8 Transcript 89/7-90/6]. He said, "*the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age care home, we would protect one life. The same number needed to vaccinate to prevent one person from dying in a 65-year old cohort was 1,000, and of the number needed to vaccinate -- to prevent one life -- save one life in the 50-plus cohort is 8,000. So by the time we get to children and young people who have no underlying health conditions, then the number needed to vaccinate to prevent one adverse outcome -- clinical outcome, not safety outcome -- is in the many tens of thousands.*"

Lack of appropriate medical treatment, medicines, and equipment

75. The Inquiry is going to hear from witnesses and has other evidence before it of

appalling neglect, including:

i. The routine application of Do Not Attempt Resuscitation (DNAR or DNACPR) orders on the files of care home and nursing home patients. There is evidence before the Inquiry that DNARs were applied to care home residents and patients without discussion with them or their families, which had the effect of preventing that patient's admission to hospital if their symptoms worsened. CBFJC share the concerns raised in an email from HAFOD (an organisation that operates care homes and nursing homes in Wales) to CIW and the Welsh Government that DNARs were used as a proxy for 'Do Not Treat' [INQ000500163].

ii. This same email [INQ000500163] includes the following harrowing account of the circumstances of the death of a resident who did not receive adequate treatment and care:

"For whatever reason, perhaps because they weren't confirmed as Covid-19, or perhaps because sufferers can take a turn for the worst and death can come on quite quickly, no palliative care package was put in place by the GP and controlled drugs were not issued to try to ease them with any possible suffering...[The patient] unfortunately passed away within 24 hours and the manner of their passing has affected some of the staff quite badly with [the patient] struggling to breathe and in effect slowly suffocating to death. Nobody should have to die like this. I get the fact that these are extraordinary times and we are in the middle of a crisis, the like of which none of us have seen before. However, there appears to be race by GP's to place DNACPR on lots of individuals, which would mean automatic non-admittance to hospitals and possibly many more examples of these horrific deaths, and with no apparent thought as to how if people suddenly take a turn for the worst how they may be helped to pass in a more comfortable and humane way… Care homes do not have a general supply of stock medication supplies for end of life care, nor access to oxygen. How confident are we that residents and their families understand the implications of a DNACPR?"

76. A combination of factors affected the ability of care home residents in Wales to access medical treatment.

77. The directive for GPs to shift to remote consultations where possible in order to reduce the risk of infection meant that interactions between GPs and care home residents were often conducted virtually. Combined with the suspension of non-Covid healthcare services for long periods of time, this shift meant that for many residents, regular check-ups, diagnostics and timely medical interventions were delayed or missed entirely. This had a particular impact on

care home residents due to the prevalence of chronic conditions and complex health needs amongst this population. It is CBFJC's belief that this contributed to a significant decline of care home residents through worsening health conditions, undiagnosed illnesses, and, in some cases, preventable deaths.

78. Furthermore, many care homes in Wales have inadequate digital infrastructure. Poor internet connectivity, particularly in remote areas of Wales, and a lack of access to devices such as tablets exacerbated the difficulties care home residents experienced in having their healthcare needs met in a timely manner.

79. Of great concern are presentations that were given to care homes in Wales in early March 2020 which advised that antibiotics and antivirals did not work in response to Covid-19, that the required treatment was ventilation, but that older people would not be ventilated and that care home residents would not be considered for this treatment [INQ000598462]. These shocking presentations demonstrate a complete disregard for the lives of care home residents by the Welsh Government.

80. In a similar vein, there is evidence that care home residents in Wales could not always access hospitals when they needed them. Ambulance teams were reluctant to transfer residents to hospital, and almost half of Local Authorities in Wales reported that necessary transfers of residents to hospital were not undertaken. The witness statement of Helen Hough, an owner and manager of a care home in Wales, details an ambulance team refusing to take a resident to hospital because they had a temperature, and the ambulance team's instructions that they were not supposed to transport anyone from a care home [INQ000587639_0006-7].

81. Due to a pre-pandemic decision related to oxygen prescriptions, many care homes in Wales did not have oxygen facilities on site and oxygen could not be held in stock, even for emergencies. Many care homes were therefore unequipped to look after residents who were very unwell and in need of oxygen therapy even though it was acknowledged that oxygen relieved the stress on patients' airways. Helen Hough wrote, in an email of 4 May 2020 to the Welsh Government: "*we cannot give any oxygen relief at all, and as this is the only treatment for COVID19 this is disgraceful, it is 'on tap' at a hospital so patients in hospital will already [be] receiving better care than what we can give at a care home*" [INQ000598472].

82. Further, care homes in Wales were often unable to provide residents with good-quality palliative and end-of-life care. Care homes do not usually stock the medication supplies needed for end-of-life care and would usually receive considerable nursing support to manage end-of-life care effectively. Yet during the pandemic nursing support was stretched thin and some care homes in Wales felt they were being asked to operate outside of their registrations by

fulfilling the functions of nursing homes without appropriate oversight and support to provide residents with good-quality care in their final days. Many care home staff, through no fault of theirs, lacked the experience and training necessary to administer end of life medication, and in these circumstances many residents endured unnecessary suffering.

83. The evidence summarised within this statement clearly demonstrates how extremely vulnerable care home residents and their families were failed by decision-makers. What makes the position even worse, is that these decision-makers knew what was happening and that it was wrong. For example:

    i. Within the emails of CIW and the Welsh Government on 6 April 2020 (already referred to at paragraph 74 [INQ000500163]): "*family members will be distraught if they are aware of these details. In these extraordinary conditions it is imperative that people who die in care homes with Covid 19 are treated with dignity, compassion and can be made as comfortable as possible*."

    ii. Emails of the group member, Helen Hough, to the Welsh Government on 1 and 4 May 2020:

        "I do not know how long it is going to take before relatives of the deceased speak to one another and realise they are not being treated with the same importance as England (less than 9 miles from here)" [INQ000598470].

        "*I do hope, when is [sic] this is over, this is all thoroughly investigated, because I and many other Managers will be stating what a diabolical shambles this is in Wales, and possibly causing many unnecessary deaths…From a very distraught tired nurse feeling helpless…*" [INQ000598472].

Impacts

84. Impacts experienced by residents and their families, additional to those already mentioned, include but are by no means limited to, the following:

    i. an absence of bereavement support offered by care homes, both practically and psychologically. Members of CBFJC feel that they were emotionally isolated and left entirely on their own to process the death of their loved one.
    ii. a substantial lack of communication from care homes about the condition of loved ones or on other issues affecting the homes. Many members found communication to be late or poorly timed, with others stating that care home management would rebuke all

attempts at contact. One member specifically recalls that they were unaware of the fact that Covid-19 was prevalent in the home until after seeing the death certificate. This problem was particularly acute in connection with the lack of information about the final hours (and sometimes days) of a loved one's life.

iii. problems with remote communication (connectivity being particularly poor in some regions of Wales), including when saying last goodbyes with calls cutting out mid conversation.

iv. throughout the pandemic, various restrictions were placed on visits to nursing and residential homes. These restrictions heavily impacted the families and loved ones of care home residents. CBFJC members experienced deep emotional distress, including feelings of guilt, due to the inability to visit and support their relatives.

v. rules and restrictions were often contradictory at times with regards to care home visits during the pandemic. This led to an inequity of experience when it came to saying goodbye to loved ones. Some group members were able to be by their loved one's side when they died, whereas other members were forced to say goodbye to them from the outside of a care facility window or via a video call. Heartbreakingly, some members were not able to say goodbye to their loved one at all.

vi. substantial feelings of isolation and loneliness that contributed to a decline in mental health, including increased anxiety, depression, and cognitive decline in those with dementia. And due to the limited access to homes for family members, many care home residents lost their primary advocates for their health, which further contributed to their deterioration.

vii. a lack of dignity, both during treatment and in death, for example dying without adequate hydration or pain relief. Several members received their loved one's personal belongings in a bin bag which was securely tied and were told to wait two weeks before they could open the bag. One member was given another patient's belongings which were soiled and soaked in urine. Some members had to wait months before their loved one's belongings were returned. Other members noted that their loved one's belongings had gone missing, despite the fact that they were listed on the admission form. Witnessing your loved one being treated in such an undignified way following their death deeply impacts on the anger and frustration felt during the grieving process.

viii. an absence of practical support on what to do after the death of a loved one. Some were told to burn their belongings; others were told to dispose of them in the rubbish or wash them. Bereaved members had to navigate the process of registering the death with the various restrictions in place. Many members were not informed upon their loved one's death that you were not allowed to embalm, wash

and/or dress your loved one after they had died of Covid-19.

ix. Many members had to engage in complex and lengthy complaints procedures and received inaccurate, contradictory and unsatisfactory responses. These lengthy complaints processes have prolonged the bereavement of so many members of CBFJC and hindered their ability to obtain some sort of closure. Some family members have been provided with subsequent contradicting information concerning their loved one's cause of death years later and have uncovered distressing information such as DNACPRs without the family's knowledge. The inadequacy of the National Nosocomial COVID-19 Programme (referenced above) is part of the same problem as is the lack of inquests, and have resulted in the bereaved lacking answers as to how their loved ones died.

13 June 2025