Witness Name: Catherine Griffiths
Statement No: 1
Exhibits: 8
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IN THE MATTER OF THE UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF Catherine Griffiths

I, Catherine Griffiths, member of COVID-19 Bereaved Families for Justice Cymru ("CBFJ Cymru") make this statement on behalf of CBFJ Cymru. In making this statement, I have consulted with the lead members, when preparing some of the responses to several of the questions posed by the Inquiry under a Rule 9 request. This statement is in response to the COVID-19 Public Inquiry's request for evidence under Rule 9 of the Inquiry Rules 2006 dated 25 June 2024, in respect of Module 6. CBFJ Cymru has been granted Core Participant status by the Chair in respect of Module 6 of the Inquiry. The request sets out 10 questions which I have taken in turn below. However, before I address these questions, I would like to explain the context and background behind my statement and how I became involved with the group.

1. My father was Group Captain Harold Abraham Griffiths, he was aged 86 and he lived in a care home in I&S. He died on 17 November 2020, after he contracted COVID-19 in his care home. Prior to this he had enjoyed robust physical health and despite his dementia, he had a good quality of life. He loved Wales, rugby, singing - so many things but most of all he loved us, his children and grandchildren.

2. He was brought up in Dinas Mawddwy, and attended Dolgellau boys grammar school until he was 18 years old. Welsh was his first language, and he left school with a place at Durham University to study maths. He was a remarkably intelligent man with a mathematical mind and a photographic memory. He would have excelled in life no matter the path he chose. However, instead of university he was called to national service. He joined the RAF after school with the

goal of becoming a pilot. Unfortunately, at 6 foot 4 he was too tall be to be a pilot, so he became a navigator instead, allowing him to put his prodigious mathematical mind to good use.

3. Dad lived life to the fullest and was considered somewhat eccentric. Following his death, many senior RAF Officers, including an ex-Air Chief Marshall wrote to us noting Dad's extraordinary qualities. The RAF does not encourage mavericks, but Dad defied this convention. He was a one-off. He initially failed the officer's exam, a result of his Welsh tongue and slightly imperfect English. My Mother was always correcting his grammar. Despite this, the RAF saw something within him. He was a natural leader of men and with his extraordinary aptitude, Dad rose through the ranks of the RAF reaching the rank of Group Captain; a feat to which the Air Chief Marshall remarked was a testament of his ability, skill, grit and charisma.

4. Dad enjoyed a number of hobbies and interests. He was a competitive man and a keen sportsman, playing rugby for both his school and the RAF, although his career was cut short by an ACL injury when he was a young man. His true passion however was golf. He channelled this enthusiasm for the game and subsequently became the secretary of the RAF Golfing society after retiring – he was particularly proud of his single figure handicap. He was also a bit of a news junkie; it was rare to find him without a newspaper – anything to increase his knowledge. Quiz nights were a particular favourite within our household, a consequence of his competitive nature.

5. Dad's first love was his family. My mother, Elisabeth, died when I was a baby and my father wore a black tie every day for a year, in her memory. I lived with my paternal grandparents, Nain & Taid, in Dinas Mawddwy, until Dad met and married the woman who became my mum - Jennifer. We had a happy family life. Mum died suddenly and unexpectedly in 2018 from sepsis. This loss hit my father very hard.

6. Soon after mum's death, my father entered a care home in Harwich. Dad had been diagnosed with Alzheimer's Disease in his early 80s and with the loss of Mum, who was his carer, it was the safest place for him. I moved my Father from the east coast of England to I&S in February 2020. I wanted to bring him home to Wales and felt that speaking Welsh, his first language, would offer an excellent opportunity for brain stimulation. I wanted Dad to be near to me so that we might enjoy more time together. He loved the new home where he was

surrounded by and cared for by Welsh speakers. For the briefest period of time we were comfortable and happy. We often went for day trips in the car, or he came to my home.

7. However, to our dismay, the pandemic hit and all of a sudden, we were unable to see each other. We spoke frequently on the phone and despite his dementia, Dad had periods of lucidity. Although we couldn't meet in person, these calls were deeply precious to us both. We talked about Dad's long experience as a navigator and the various aircraft he had worked on, he told me jokes and we even discussed politics and current events; Dad read The Times every day and in the main, had some awareness of what was happening in the world. In the summer of 2020, Dad asked me if I felt that the government was looking after us and was making good decisions during the pandemic; poignant and prescient, in retrospect.

8. The first lockdown was intensely difficult. I was terrified for my father's safety and if he could have managed the steep stairs in my home, I would have brought him to live with me. The restrictions imposed were difficult to deal with. I had to wave through a window when I visited Dad on his 86th birthday, which made him (and then me), distraught. Shortly after, for my 60th birthday, we were allowed to meet in the garden but could not touch. It was excruciatingly painful to stop Dad from hugging me.

9. As a retired A&E nurse, I have some knowledge of infection control and was fearful that systems might not have been in place for the protection of the vulnerable residents at his care home. The carers were resolutely cheerful, kind and thoughtful to me and I know they looked after Dad with great expertise and compassion, but they were also very afraid and occasionally shared their concerns with me. One carer confided in me that "it feels like we are waiting for the inevitable, I am very frightened".

10. As the second wave progressed and the numbers of deaths in Wales increased and became ever more shocking, the feeling of inevitability grew. On 9th November 2020, I received the late-night call I had been dreading; Dad had both tested positive for COVID-19, and had fallen, and an ambulance had been called. I insisted on speaking with him on the phone - visits were not possible during this time. Throughout the call he was sweetly hopeful, and his stoical self. He was very pragmatic, and promised he was okay. He believed in hospitals and the medical systems, never questioned it. I said goodbye. This was the last time we would ever speak before he died on the 17 November 2020.

11. I have been on anxiety medication since this time, as a result of everything that happened to my Dad, and to me, during his time in the care home. I also underwent an 18 month course of psychotherapy, which started in August 2020.

Overview of CBFJ Cymru

12. CBFJ Cymru originated as an autonomous group out of the COVID-19 Bereaved Families for Justice ("CBFJ") group. CBFJ Cymru was set up by Welsh members of CBFJ on 15 July 2021. CBFJ Cymru is a Welsh focused group dedicated solely to campaigning for and giving a voice to those bereaved by COVID-19 in Wales, ensuring that there is proper scrutiny of all governmental decision-making relevant to Wales, including those decisions made in Westminster and by the devolved administration in Wales.

13. Since its establishment, CBFJ Cymru has become the most prominent organisation in Wales in the discourse surrounding the COVID-19 pandemic to ensure proper scrutiny of decision-making impacting on Wales in a UK Inquiry. CBFJ Cymru has also played a leading role in calling for a Welsh Inquiry and has campaigned tirelessly for justice for families in Wales who are experiencing bereavement due to the COVID-19 pandemic.

14. CBFJ Cymru has actively engaged with the Welsh Government and the UK Government on a number of occasions. It met with the former First Minister of Wales, Mark Drakeford, numerous times (7 October 2021, 2 December 2021, 26 January 2022, 24 February 2022, 30 August 2022). CBFJ Cymru also met with the former First Minister's team on several occasions. The First Minister included CBFJ Cymru's feedback in his initial response to the Prime Minister on the draft Terms of Reference ('ToR') for the UK Inquiry and announced that CBFJ Cymru's experiences had been directly reflected in the Welsh Government's response to the final ToR. It met the Health Minister and Deputy Chief Medical Officer for Wales in relation to the investigation of Hospital Acquired Covid-19 in Wales and then separately with Dr Name Redacted It collected 2,116 signatures for a petition calling for a Welsh Inquiry. CBFJ Cymru has engaged with the UK Inquiry set up process (responding to the ToR consultation, meeting the Chair in Cardiff on 15/03/22, and its legal team meeting with the Inquiry Team).

15. CBFJ Cymru's vigorous campaigning directly led to the Welsh Government investing £4.5 million into the investigation of nosocomial infections in Wales from Covid-19. More recently,

CBFJ Cymru has worked with the following organisations within the Welsh Government, namely: The National Bereavement Steering Group, as well as John Moss (Bereavement Lead in the Welsh Government), to implement bereavement support in hospitals; Heléna Herklots the Older People's Commissioner for Wales to lobby for change concerning DNACPRs, as well as the Wales Evidence Centre. CBFJ Cymru has lobbied and worked with all Welsh health boards in relation to bereavement support and to influence change and reform to their 'Putting Things Right' complaint process. CBFJ Cymru has liaised with MS Mark Isherwood, Chair of the Cross Party Group on Hospices and Palliative Care in the Welsh Parliament. It met with AFCP (Advance & Future Care Planning Strategy Group) on 29 November 2023 and has been liaising with Professor Mark Taubert, chair and national strategic lead of AFCP, to lobby for change in the DNACPR decision making process in Wales; an issue which is very much live in Module 6 and upon which CBFJ Cymru will be able to assist the Inquiry. The Group have also liaised with Care Inspectorate Wales and Care Forum Wales.

16. CBFJ Cymru are acutely aware of the importance of full and proper scrutiny of decision-making in Wales in respect of COVID-19.

17. CBFJ Cymru is not a legal entity. It is a non-political, not for profit group set up by the COVID-19 bereaved in Wales.

18. CBFJ Cymru incorporate both primary and secondary aims which I have set out below:

    a. CBFJ Cymru Primary aims:

        i. to understand why decisions were made and for errors to be publicly acknowledged so lessons can be learned;
        ii. to call for a Wales-specific Inquiry;
        iii. to work with the Welsh Government to ensure Wales is fully represented in the UK COVID-19 Inquiry;
        iv. to call for a Wales COVID-19 Inquiry special purposes committee that will investigate any potential gaps in the UK COVID-19 Inquiry.

v. to ensure that all recommendations made in any pandemic planning exercise be applied and assessed, regularly. (This includes both past exercises and those still to be held).

b. CBFJ Cymru Secondary aims:

i. to call for an investigation into all COVID-19 related infections and deaths in Welsh care homes;
ii. to ensure changes to infection control in care home settings in Wales are implemented;
iii. to support members through the care home complaints process;
iv. to ensure bereavement support, both practical and psychological, is in place following COVID-19 deaths in care homes;
v. to champion the rights of older people in Wales including human rights, ethical practices, DNACPR process, withdrawal of treatment, Frailty Score, dignity in death;
vi. to promote patient privacy and the right not to be photographed for books and PR purposes when dying/deceased in NHS Wales hospitals;
vii. to raise awareness in Wales of why a public COVID-19 inquiry is needed;
viii. to ensure that the Welsh Government establishes and maintains a care home register in Wales;
ix. to ensure the provision of adequate PPE, equipment & medication and guaranteeing the procurement process is maintained;
x. to improve ventilation or employ the use of HEPA filters across care homes in Wales;
xi. to establish a care home strategy that adheres to the lessons learned from the COVID-19 pandemic and other exercises and reports such as Operation Shipshape (2003) in order to adequately prepare for the next pandemic;
xii. to promote an integrated approach towards care in Wales linking the primary, secondary and tertiary sectors to ensure coordination and enhance communication between services in order to provide the highest quality of care to those who require it.

19. CBFJ Cymru is recognised by the Welsh Government and other political parties in Wales as the key group representing and campaigning for the rights of those who are bereaved in Wales as a result of COVID-19 and related issues.

20. CBFJ Cymru is a group comprised of several hundred individuals, led by Anna-Louise Marsh-Rees and Sam Smith-Higgins, who represent the full spectrum of families in Wales who are bereaved by COVID-19.

21. Individuals can join CBFJ Cymru either by signing up to the autonomous CBFJ Cymru Facebook group, or by signing up with Harding Evans Solicitors.

22. Many of the members of our group have professional experience working in sectors involved in or impacted by the UK and Welsh Government's risk management and civil emergency planning. They thus have valuable first-hand experience of how deficiencies in pandemic preparation subsequently contributed to the losses the group suffered as a whole.

Key Impacts and Concerns Raised by CBFJ Members

23. During the relevant period myself and other members of CBFJ Cymru encountered countless and wide-ranging failings in their dealing with the care sector in Wales. CBFJ Cymru's members are extremely concerned that COVID-19 was left to run rampant through care homes leading to an unacceptable loss of life. One of our members reported that during the first wave, more than half of the 52 residents in her father's care home lost their lives to Covid-19 during an outbreak at the care home.

24. CBFJ Cymru is particularly concerned with the total absence of bereavement support offered by care homes, both practically and psychologically, following the death of our loved ones; there is a general consensus amongst members of the group that the bereaved were simply forgotten about. Members of CBFJ Cymru feel that they were emotionally isolated and left entirely on their own to process the death of their loved one.

25. Personal Protective Equipment (PPE) was of particular concern during the preliminary stages of the pandemic. It was clear that stocks were running low as evidenced by Albert Heaney (Chief Social Care Officer, Welsh Government) advising that PPE was only to be worn with

symptomatic care recipients. This lack of universal PPE coverage likely contributed to the spread of the virus. One of our members ran a care home during the pandemic and reported difficulties in sourcing PPE; they were forced to try and procure essential PPE from Amazon because of the supply issues. Supply issues also extended to other essentials including oxygen **(CG/01-INQ000520997).**

26. Members of the Group are particularly concerned about the delays to testing asymptomatic care home residents and staff. Both Mark Drakeford, the former First Minister of Wales, and Vaughan Gething, former Minister for Health and Social Services, repeatedly dismissed the suggestion of widespread asymptomatic testing of care home workers and residents. This meant that when England introduced the measure on 28 April 2020, Wales lagged behind, only enacting a similar policy on the 16 May 2020. From the groups perspective it appeared that the First Minister had given in to mounting external political pressures, rather than taking into account the needs of those in the care sector.

27. The testing of care home staff would continue to be a significant issue throughout the pandemic. Many CBFJ Cymru members found that Lateral Flow Tests (LFTs) were not adequately available, and that many symptomatic staff members continued to work , despite not receiving a negative PCR test result. One of our members reports that a care home worker informed them that a PCR test would take up to two days to be returned to them whilst they continued to work. Even after the Welsh Government introduced a weekly care home testing policy, many of us found that testing was still applied inconsistently. The testing of staff in my father's home wasn't weekly but rather more random, often with two weekly intervals.

28. Many of our members were particularly frustrated with the Welsh policy to encourage the discharge of patients from hospitals to care homes in order to increase hospital capacity. Many patients were released into the care system without a negative test, subsequently leading to outbreaks within the home. It is our view that the decisions taken by the Welsh Government directly contributed to the virus' ability to spread, ultimately leading to more people contracting the virus and sadly losing their lives. Furthermore, the eventual decision to test patients upon discharge from hospital to care homes was taken a full two weeks after the UK Government introduced the policy in England. Between March and April of 2020, 1,097 patients were discharged to care homes without being tested for COVID-19 **(CG/02-INQ000385158)**. Many

of our members confirm that patients were discharged from hospitals to care homes without a negative test.

29. There was a substantial lack of communication from care homes about the condition of loved ones or on other issues affecting the homes. Many found communication to be late or poorly timed, with others stating that care home management would rebuke all attempts at contact. One member specifically recants that they were unaware of the fact that COVID-19 was prevalent in the home and was the inevitable cause of death until after seeing the death certificate. CBFJ Cymru regards this lack of communication as resoundingly unacceptable.

30. A significant concern of CBFJ Cymru was the risk of staff spreading the virus between homes. The use of agency staff was commonplace. This inevitably led many staff to move between homes or even region to region. This continuous source of movement likely contributed to the spread of the virus between homes. Albert Heaney admits that despite the risk posed, the pressure on the system put the social care sector into a position in which they could not prevent this. This was particularly frustrating to our members who found that many care homes were still accepting new patient discharges from hospital.

31. Care Inspectorate Wales (CIW) suspended inspections, and so care homes were effectively operating unregulated and unchecked for the initial months of the pandemic. With this lack of oversight in place, CBFJ Cymru is particularly concerned as to whether proper procedures and policy were followed.

32. 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, had no choice but to work.

33. Our members raised a number of concerns over staffing figures. These concerns were shared by members of the Welsh Government; Albert Heaney remarked in his witness statement that the sector was 'fragile' and that he held serious concerns over the staffing figures **(CG/03-INQ000389958)**. Care homes were often understaffed with many care workers absent as a

result of COVID-19. This resulted in a dramatic drop in quality of care afforded to our members loved ones. In 2021 it was estimated that Wales had 72,100 people employed in the adult social care sector, representing about 6% of total employment in Wales; 19,637 of these are domiciliary care workers. It was reported in May 2021 that Denbighshire saw 15% of its local authority social services workforce take time away from work due to COVID-19. Further reports indicate that staff absence varied between 10% to 35% throughout the relevant period of the pandemic resulting in the need for staffing mutual aid or the introduction of agency staff. Both of these issues further heightened the risk of infection being introduced into homes.

34. We present below a list of the key decisions and actions taken by the Welsh Government in respect of the adult social care sector during the relevant period:

    a. On 19 March 2020, it was stated in a written statement that if neither the care worker nor the individual receiving care and support is showing symptoms, no PPE beyond standard good hygiene practices was necessary.
    b. On 29 March 2020, Assembly Member Darren Millar contacted Public Health Wales (PHW) regarding concerns from care home operators and managers about the lack of mandatory COVID-19 testing for new residents before admission. PHW responded that new residents should be evaluated for COVID-19 symptoms and isolated if necessary. However, if new or existing residents show no symptoms before admission, testing for the virus is deemed unnecessary as the test is intended for symptomatic patients.
    c. On 9 April 2020, PHW issued guidance titled 'Admission and Care of Residents during COVID-19 Incident in a Residential Care Setting in Wales, Version 6'. This guidance stated that negative tests are not required for transfers or admissions into residential settings. Updated guidance replaced this version on 7th May.
    d. On 17 April 2020, officials attended a meeting with PHW regarding testing and discharges to care homes. The meeting notes referenced guidance issued in England on 15 April 2020, 'COVID-19: Our Action Plan for Adult Social Care', which confirmed a policy of testing all residents prior to care home admissions **(CG/04-INQ000336421)**.
    e. On 24 April 2020, Albert Heaney (Chief Social Care Officer for Wales) and the Chief Medical Officer (CMO) sent a letter to Health Board Chief

Executives, Medical Directors, and Directors of Public Health. The letter confirmed that the Welsh Government would offer COVID-19 testing for all potential cases of the virus within care homes. The letter included that all individuals discharged from hospitals to care homes, those transferred between care homes, or those newly admitted from the community would require testing. Subsequently, no discharges, transfers, or admissions would occur until a negative COVID-19 test result was confirmed.

f. On 29 April 2020, the additional step-up and step-down guidance and updated discharge flow chart were issued making it clear that testing should take place prior to discharge from hospital. The flow chart makes it clear that a negative test would be required before discharge to a care home.

g. On 7 May 2020, Albert Heaney and the CMO wrote to care home providers and individuals of care home services across Wales highlighting the updated PHW guidance (Version 3) on the correct use of PPE for care homes and domiciliary support services.

h. On 16 May 2020, the Welsh Government issued a press release stating that COVID-19 testing would be extended to all care home residents and staff in Wales **(CG/05-INQ000182446)**. The Minister for Health and Social Services, Vaughan Gething, announced this decision following the latest and most up to date scientific evidence. The press release omitted to clarify that it was restricted to care homes without an outbreak in the past 28 days. This restriction was confirmed in a letter from the Chief Social Care Officer and CMO to care home providers and Responsible Individuals (RIs) for adults and children on 16 May **(CG/06-INQ000368564)**. The letter clarified that all symptomatic and asymptomatic staff and residents in care homes with outbreaks in the 28 days before 2 May would now be offered testing. The decision came nearly three weeks after England began the rollout of COVID-19 testing for all staff and residents on 28 April 2020.

i. On 1 June 2020, the Deputy Minister for Health and Social Services wrote to the Older People's Commissioner outlining that testing in care homes was in the process of being rolled out. However, priority was given to care home outbreaks followed by care homes with more than 50 registered beds.

j. From 15 June 2020, all care home staff would be offered a weekly test for a 4-week period. The Welsh Government stated it understood the importance

of stopping the spread of the virus across and within care homes at the earliest opportunity.

k. On 10 July 2020, ministerial advice was submitted to and agreed by the Minister and Deputy Minister for Health and Social Services to continue with the weekly testing of staff in care homes. At this stage regular testing of care home residents was not recommended, notwithstanding that SAGE advised in June 2020 that care home residents should be tested every seven days.

35. CIW also suspended inspections resulting in care homes operating unregulated and unchecked for the initial months of the pandemic, pausing in March 2020 before resuming in a phased manner from July 2020. With this lack of oversight in place, CBFJ Cymru is particularly concerned as to whether proper care procedures were followed.

Infection Prevention and Control Measures

36. CBFJ Cymru note that the lack of adequate infection control was a key devastating factor at the heart of the COVID-19 Pandemic.

37. Care homes were expected to adhere to detailed Welsh Government approved Infection, Prevention and Control (IPC) guidelines. However, guidance issued by Public Health Wales before the pandemic dealt only with IPC measures needed for norovirus and/or influenza.

38. Due to the nature of transmission of the virus, staff in care homes across Wales required extensive retraining in IPC measures. The Welsh Government delivered this training remotely through the use of training videos. This was conducted as part of a scheme delivered by the Welsh Government in partnership with Digital Communities Wales. To date, 745 devices have been delivered to 401 care homes, with 313 care homes receiving staff training on the NHS Wales Video Consulting Service. It is CBFJ Cymru's view that this training was subpar.

39. These guidelines required the maintenance of social distancing, hygiene practices, and thorough decontamination of shared areas after use. RPE and PPE were to be used at all times by staff and visitors to reduce the risk of transmission. Many of these measures were troublesome to implement. Social distancing proved particularly difficult within care homes.

Many of our members loved ones suffered from dementia and consequently, these measures were difficult to comprehend or remember.

40. There were often communication issues between care homes and family members. Many were not informed of what was happening to their loved ones or the IPC measures in place within the home. This lack of clarity and transparency placed a significant level of stress on our members who held concerns over the standard of care their loved ones were receiving. One of our members remarked that the only thing she knew about the IPC conditions in the home before her mother passed was that the manager stated they had cordoned off two separate areas; one for those with COVID-19 and one for those without. This lack of clear communication as to what homes were doing is unacceptable.

41. Visiting policies were based on a dynamic risk assessment, taking into account the vulnerability of people living and staying in the care home. This risk assessment considered the risks to residents, staff, and visitors and was adapted to the individual circumstances and needs of each care home, as well as the local or national level of COVID-19. Upon entry, visitors would doff face coverings, nothing more than a basic surgical mask. This could only be removed once seated and provided there was a fixed, floor-to-ceiling, wall-to-wall screen in place between the visitor and resident, as stipulated under alert level 4 precautions. Person to person contact was mostly barred, or extremely limited. These measures were profoundly isolating for our members loved ones.

42. During the COVID-19 pandemic in Wales, care homes faced significant challenges related to ventilation. Ensuring proper ventilation was found to play a crucial role in reducing the spread of the virus relatively early in the pandemic. Many care homes in Wales simply lacked the infrastructure necessary to adequately ventilate homes. Subsequent guidance was developed and provided to homes dictating the need to open windows or engage other mechanical ventilation options to circulate fresh air effectively.

43. I personally, as well as many members of CBFJ Cymru, experienced firsthand the systematic failure of inadequate infection control with staff failing to wear PPE, adhere to guidance or ensure social distancing. As a result of our firsthand experiences, many members strongly believe that poor infection control within care home settings led to the rapid increase in transmission of the disease. We did everything within our power to keep

our loved ones safe; we stringently followed Welsh Government guidance; avoided visiting homes; kept to social distancing and donned PPE. Yet these efforts were all for nought. The agonising pain and feeling of betrayal, felt by myself and many of our members when our loved ones contracted COVID-19 within a care home setting is unfathomable. The lack of PPE and RPE available; the use of agency staff who were moved between homes; the lack of testing available all propelled the transmission of COVID-19. The poor infection control impacted on the life expectancy and quality of countless lives.

44. PPE was a pervasive issue throughout the pandemic for our members.

45. PPE was rationed during the preliminary stages of the pandemic. Albert Heaney was responsible for issuing guidelines for the use of PPE, sending a letter on the 19th March 2020 advising that PPE was to be worn by social care staff providing direct personal care to someone with symptoms of COVID-19. PPE was not required to be used where a care receiver was asymptomatic. One of our members was so concerned after hearing this news they themselves offered to make calls to procure PPE for the care home but received no response.

46. When visiting loved ones, our members often expressed concerns about the adequacy of PPE. One member noted that the quality of the PPE provided was alarmingly low, consisting only of a simple paper surgical mask, and gloves. This inadequate protection left members feeling underprepared and unsafe, particularly during the emotional moments of saying farewell to their loved ones. Additionally, many of our members, being at higher risk themselves, faced the difficult decision to forego visiting their COVID-positive family members in their final moments, to avoid unnecessary exposure and risk to their own health.

47. One of our members believed that following the death of a loved one, the care home deliberately falsified PPE records in order to show they were compliant with guidance. It is felt that in the absence of inspections by CIW that many care homes were appearing to cut corners or were avoiding their duties entirely.

Visiting Restrictions

48. 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. Our members experienced deep emotional distress due to the inability to visit and support their relatives. This separation led to feelings of guilt and anxiety. Many care homes relied on the use of virtual communication methods for residents to maintain contact with their loved ones. However, for many, these communication methods were challenging and confusing, especially for residents who had difficulties with technology. This, combined with internet connectivity issues often led inadequate and unsatisfactory communication between residents and their families.

49. Many CBFJ Cymru members report that their loved ones felt substantial feelings of isolation and loneliness. This isolation likely contributed to the decline in mental health, manifesting as increased anxiety, depression, and cognitive decline in those with dementia. Due to the limited access to homes for family members, many care home residents lost their primary advocates for their health. It is well understood that those in care homes may be less likely to speak out about ailments making it necessary for loved ones to do so for them. This lack of advocacy likely contributed to the physical deterioration of family members.

50. Paid caregivers often faced substantially increased workloads due to heightened infection control measures and staffing shortages. Additionally, staff were now the sole support system for residents, in the absence of family visits. These factors likely contributed to heightened stress among staff resulting in a decrease in care quality afforded to our loved ones in their last moments.
51. Delays from the Welsh Government on the issue of visitation guidance led to prolonged periods of uncertainty and distress for residents and their families. Guidance was typically issued reactively as a response to the rising case numbers within homes rather than proactively. Typically, guidelines lacked specificity or were ambiguous in nature and were even at times contradictory. This made it difficult for care home providers to interpret and implement the policies correctly. The guidelines were frequently updated, often without clear communication from the Welsh Government, leading to confusion and inconsistent application across different care homes.

52. These inconsistencies often led to significant variation in how different care homes applied the visiting guidelines. Some homes were more stringent in their application than others. This

led to an inequitable distribution of care across Wales. This lack of a unified approach resulted in discrepancies in the interpretation of guidelines, leading to frustration among families and care home staff.

Loss of access to healthcare

53. Due to visitation restrictions, many residents lost their access to healthcare professionals. These restrictions meant that regular check-ups, diagnostics, and timely medical interventions were delayed or missed entirely. Many care home residents experience chronic conditions and complex health needs that did not receive the adequate or necessary medical attention. It is CBFJ Cymru's belief that this inaction contributed to a significant decline of care home residents through worsening health conditions, undiagnosed illnesses, and, in some cases, preventable deaths. We are unlikely to truly know the total scale of the pandemic due to these hidden variables and subsequent knock-on effects from public policy.

54. Pre-existing health conditions were prevalent among many of our member's loved ones, such as diabetes, hypertension and cardiovascular diseases were common among a number of other comorbidities. With limited access to healthcare professionals both within and outside of care homes, many residents saw a reduction in the monitoring and management of their conditions. Many residents who required specialised care in the forms of occupational therapy and cognitive behavioural therapy lost regular access to services and their support networks meaning many did not receive the comprehensive care necessary for their well-being and rehabilitation. This inevitably led to an overall decline in their physical and mental health conditions.

55. We bore widespread witness to the deterioration in the mental health and well-being of care home residents. This was a likely result of the loss of regular interaction with healthcare professionals and isolation from friends and family. The restrictions greatly exacerbated underlying mental health issues and heightened feelings of anxiety, loneliness and depression among residents. These feelings were even greater among those with pre-existing mental health conditions and cognitive impairments such as dementia. The total psychological toll the pandemic has had on our loved ones has been profound.

56. It is impossible to quantify the long-term implications of delayed medical care; inadequate management of chronic conditions; and the impact on mental health among residents of the care sector in Wales. The adult social care sector may face ongoing challenges in addressing the aftermath of these restrictions, requiring significant resources and support to mitigate the long-term impact on residents' health and well-being. CBFJ Cymru are adamant that long term investment is necessary to help address the long-term effects of the healthcare needs of those within the adult social care sector.

57. The emotional and psychological impact of the pandemic was also felt by care home staff. One of our members ran a care home with her husband during the pandemic. The emotional strain of running a care home during the pandemic had an enormous impact on her husband's mental health, with concerns about controlling the spread in the face of inadequate PPE, lack of testing and lack of support from the Welsh Government. The weight of this burden tragically led to her husband taking his own life. Care Forum Wales recognised the "enormous pressure care home owners and their staff have been under as a result of the pandemic".

End of Life Care and DNACPR's

58. An important part of CBFJ Cymru's campaign is to champion the rights of older people in Wales. Many of our members including myself and our families faced substantial pressure to accept or place their loved ones under 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders. This pressure often arose from the use of Clinical Frailty Scores, and other various scoring systems which assessed a patient's likelihood of recovery and overall health status. Whilst these scores can guide medical decisions, their use as the primary basis for recommending DNACPR orders, without considering the individual's specific circumstances and wishes, caused significant stress and emotional turmoil.

59. We have many cases where neither the patients nor their family were consulted about the decision to put a DNACPR in place. We have members who were next of kin to their loved one and only found out that a DNACPR was put in place when they requested copies of their medical records. Alarmingly, some members were not consulted on the decision to put a DNACPR in place despite the fact they held Power of Attorney over their loved ones' Health and Welfare.

60. CBFJ Cymru believe that the need to alleviate the strain on NHS resources seems to have been a significant factor behind the widespread mass deployment of DNACPRs. Families subsequently felt coerced into agreeing to DNACPR orders, suspecting that these decisions were more about managing limited medical resources than about clinical need. This perception undermines trust in the healthcare system, as it suggests that some lives are deemed less worthy of intensive care based solely on frailty scores.

61. End of life care was often subpar and often lacked the necessary care and compassion required. Many of our members have shared with us troubling stories regarding the discharge of their loved ones from hospitals to care homes. Patients were typically discharged with a care package that was intended to supply necessary fluid and pain relieving medication. Unfortunately, this care package was not always administered properly by care homes.

62. Members report that access to essential medication was limited. Typical pain relieving measures such as morphine drivers were often rationed or simply unavailable. Additional life preserving medications such as antivirals or antibiotics were often inaccessible. Members report feeling abandoned by the health system leading to the belief that care home residents were expected to recover or die on their own, with little support.

Vaccination programme

63. CBFJ Cymru has found that the vaccination programme posed a number of issues for our members, carers and care home residents.

64. The Welsh Government recognised care workers as a priority group to receive a vaccination, however, unpaid carers were left in the dark. This unfortunately affected one of our own members whose personal experience as an unpaid carer for their mother, experienced substantial difficulty in trying to prove that they were indeed a carer to access the vaccine.

65. Vaccine delivery statistics demonstrate how Healthcare, Social Care and care home staff were prioritised over care home residents and those aged 80 and over. An information card from Cardiff and Vale University Health Board on vaccination statistics dated for 18 January 2021 indicates that by this time, a vaccine had been given to 18,582 members of staff in healthcare, social care and care Homes. By the same date, a combined total of 3,351 care home residents

and those aged 80 and over in the same Health Board had received a vaccine **(CG/07-INQ000381308)**. This is illustrated by a similar information card from Hywel Dda University Health Board, dated 10 March 2021, where it shows that over 50% of Care Home Workers, and roughly 30% of Health and Social Care staff had received their second dose. This is contrasted with significantly lower figures for care home residents and over-80s **(CG/08-INQ000381309)**.

Impact of the Pandemic on CBFJ Cymru Members

66. My father died during the second wave to care home acquired COVID-19. On 9 November 2020, I received a late-night call from my father's care home informing me that Dad had both tested positive for COVID-19, and had fallen and was unable to walk. My father was admitted to hospital that night where he was given IV fluids and pain relief with good effect. He made some improvement over his 24 hour hospital stay and was discharged back to the care home with instructions for subcutaneous fluids and analgesia.

67. When my father was discharged, he was provided with a care package. The package provided necessary pain relief and fluids. The district nurses were to administer the controlled drug analgesia via syringe driver and to set up the fluids. The fluids were to be delivered via subcutaneous administration, that is, the insertion of medications beneath the skin either by injection or infusion - a very simple, effective and safe way to give a dying person fluids. I was devastated and blindsided to discover that when he was most vulnerable, the care home/district nurses had failed to administer the fluids along with the rest of the care package. As a consequence of this neglect, he was dehydrated and in pain. I called to discuss the matter in the night and the next day I received a call from the care home manager who screamed at me over the phone. She told me not to ring in the night. There was a complete lack of support. I felt helpless, alone and desperate in the face of such neglect, particularly as my immediate family lives 6,000 miles away.

68. My father's GP called me early in the pandemic to request I sign a DNACPR. The GP was incredibly callous in his conduct towards me; he didn't introduce himself and his first words were that we needed to place a DNACPR on Harold Griffiths. I was overwhelmed and completely shocked that I had been asked to make this decision, as my father was fit and healthy prior to his fall. I was also completely taken aback by the manner in which the GP had

asked me. Their justification for pressing the matter was my father's dementia, stating: "he doesn't know what he had for breakfast, he won't understand it". In spite of his dementia, my father had full awareness of his mortality and both could and would have signed this himself. The complete lack of bedside manner on display is indicative of a system wide failure in bereavement support training and management. Furthermore, I believe that these decisions were thrust upon myself and others when we were at our most vulnerable in a way that felt deliberate.

69. The following week was torturous. I live alone, my immediate family are 6,000 miles away, and we were in lockdown. 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. My brother, who lives in Hong Kong, was with us on a group WhatsApp call. I couldn't hold our father's hand as he was dying. I always promised that I would, just as I did for Mum. The images of Dad reaching out to me still wake me up, crying, sweating and with my heart racing.

70. Following his death, the home provided little support, it was very impersonal. His body was handled in an incredibly disrespectable manner. They simply zipped him up in a body bag and refused to touch him. As far as I am aware, he was cremated in soiled pyjamas. Pyjamas I had given him as a present. I would have liked to have known that my father was washed and prepared for cremation; I know that he wasn't, this was against the rules. I've laid people out in my life, it is an important part of our ritual surrounding death. Rituals give us comfort when we are saying farewell. They afford us a process that is familiar and meaningful and gives support when we most need it. I would have wanted him in something comfy, clean, decent – something he liked. It's about providing care and love, these rituals help with grief and loss, offering a cathartic release of emotion - knowing you've done as much as you can for this person who has loved you all your life. It feels like the inability to perform them diminishes this farewell. We are left with a sense of guilt, of having failed in such an important way.

71. The funeral itself was a small intimate affair in the local crematorium, attended by only ten people. This was not out of choice. My father was a very popular man. The funeral was livestreamed and attended virtually by so many. He was much loved and well respected;

friends, family, ex-colleagues, people he played golf with, all wanted to come but were unable due to the restrictions. With the kind help of the carers, I managed to retrieve two of his belongings from the care home; his RAF hat which I placed on his coffin; and a photo album about his life that Mum had made him for his 80th birthday. I couldn't give my brother my father's wedding ring.

72. My family and I still do not know exactly how our father acquired COVID-19. The care home management team have never given us a clear answer. After Dad died, one of the carers said that they were working symptomatically and were waiting up to two days for test results. We are astonished that there has been no inquiry into how, in a home with I& residents, over half contracted COVID-19. The home has provided no bereavement support whatsoever. Any communication has been in the form of completely impersonal emails. No one has phoned to check up on us. What little communication we had was that of an email informing us to pick up Dad's watch, one that I had bought him as a gift when he moved to I&S, that had been left in the home's safe. I couldn't face it, I just left it. We are obliged to put our trust in the places which care for us when we are most in need and now this trust has been sorely damaged. Ultimately, his death felt like that of a mere business transaction. My father deserved better. Everyone deserves better.

73. My father's death sadly serves to highlight a significant gap in the quality of end-of-life care in Wales and underscores the urgent need for improvement to ensure that all individuals receive the compassionate and comprehensive care they deserve during their final days. The loss of loved ones during the COVID-19 pandemic had a profound impact on our ability to grieve. I have set out below a list of the issues that demonstrate how bereavement during the COVID-19 pandemic affected those within CBFJ Cymru;

    a. We have numerous members within the group who have no idea what happened during the final days, or hours, of their loved one's lives. Poor communication between care services and families, coupled with the restrictions to visit their loved one in person, meant that many individuals do not know precisely how or when their loved one died. Many members recall receiving inconsistent and contradictory updates from care homes and hospitals.

b. Rules and restrictions were often contradictory at times with regards to 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. I myself felt that the PPE provided by the home caring for my father did not appear be adequate for the safe protection of myself or my family. We invariably had to make the tough decision to say goodbye to my father from outside the care home window in the pouring rain. My father died alone without us there to comfort him.

c. Important post-death ceremonial traditions and rituals could not be carried out, which had a significant impact on the ability to gain closure. Discrepancies also stemmed from contradicting, confusing and ever-changing rules and regulations concerning funeral services. Members recall approaching one funeral director who would allow a maximum of five attendees at a funeral whereas another funeral director within the same local area was able to offer a service with a maximum of 10 attendees.

d. Mourning for many is a vital part of the grieving process, yet the opportunity to come together and collectively grieve and celebrate the lives of our loved ones was not afforded to us. We were forbidden from sharing our grief. One member had to wait 18 months until she was able to meet with her family and friends to celebrate her mother's life.

e. Many care homes were ill equipped with the necessary technology or Wi-Fi to allow for family members to communicate with loved ones in their final hours. With the restrictions on visiting in place, this made it difficult for members of the group to communicate and to say goodbye to their loved ones at the time of their death.

f. Many of our member's loved ones were treated with a lack of dignity, both during treatment and in death. I unfortunately must refer back to my own father who received a care package from the hospital to ensure adequate hydration and pain relief. It took 24 hours for my father to be suitably outfitted with this very simple,

basic and safe equipment. He was suffering intense pain. He was dying without adequate hydration or pain relief. Unbelievable in the 21st century.

g. 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.

h. The lack of empathy and compassion shown towards the deceased and the bereaved was prolonged further by the Welsh Government's failure to sufficiently plan for and invest in adequate infrastructure for excess deaths. Such Welsh Government shortcomings resulted in capacity issues within hospital wards further placing pressure on the system to discharge COVID-19 positive patients to care facilities. This inevitably exposed facilities to the virus. This introduced the virus to facilities that should have been at the highest centre of care and attention due to the likelihood of harm exposure.

i. There was no practical support on what to do after the death of our loved ones. Some were told to burn their loved one 's belongings; others were told to dispose of them in the rubbish or wash them. Bereaved members had to navigate the process of registering their loved one's 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.

j. Some members struggled to meet the financial burden of funding funerals and other post death arrangements at a time where members might have been out of work or relying on reduced income due to the pandemic and the associated restrictions. Whilst some schemes such as furlough and "Eat Out to Help Out"

were introduced to protect employees and businesses, little to no thought appears to have been given to the impact of the financial burdens on the bereaved.

k. Many members have had to engage in complex and lengthy complaints procedures following the death of their loved one. The complaints made by members to their relevant Health Board has uncovered inaccuracies and inconsistencies; many members have received contradictory and unsatisfactory replies. I myself found that despite care home staff proving to be very helpful and sympathetic, the management of said homes were truly ambivalent towards my father and our family.

l. The lengthy complaints process has prolonged the bereavement of so many members of our group. It has hindered their ability to receive some sort of closure. Some family members have been given subsequent contradicting information concerning their loved one's cause of death years later and have uncovered distressing information such as DNACPR's being put on their loved one without the family's knowledge. The National Nosocomial COVID-19 Programme causes further stress and, sadly, delay is all too prevalent in that programme too. This, coupled with the lack of inquests being conducted into the significant majority of deaths arising from COVID-19 has resulted in the bereaved lacking answers as to how their loved one sadly died.

Disproportionate Impacts of the Pandemic on Adult Social Care Recipients

74. I and many CBFJ members feel that their loved ones were neglected on the basis of age and were viewed as 'too old'. Numerous members of CBFJ Cymru suffered the trauma of being told this. We believe that on the basis of the Clinical Frailty Score, many members felt that they were disproportionally affected by the use of DNACPRs.

75. A large proportion of our member's loved ones were part of the older generation which had no, or limited access/understanding on how to use digital devices and access telehealth during the pandemic. There was a lack of acknowledgement that older people might need help accessing and using digital technology. Additionally, many parts of Wales are very rural with poor internet connection and poor mobile phone signal. Structures could have been

incorporated within social distancing and lockdown measures to ensure that digital exclusion was avoided or kept to the very minimum at the least.

Summary of CBFJ Cymru's Formal Engagement with Welsh Government and Health Authorities

76. Since its inception, CBFJ Cymru has lobbied for changes to the response to COVID-19 in Wales. CBFJ Cymru has worked with both the Welsh Government and UK Government in pursuit of its aims. The following work has been conducted by CBFJ Cymru:

    a. it gathered together, and subsequently represents, the collective experiences of the full spectrum of families in Wales, bereaved by COVID-19;
    b. it initially worked with the Welsh Government to campaign for a Wales Inquiry. This consisted of 7 meetings with the former First Minister and the Welsh Government's Inquiry team. CBFJ Cymru also had input in the COVID-19 UK Inquiry's Terms of Reference;
    c. it has quarterly meetings with the Health Minister and Deputy Chief Medical Officer for Wales;
    d. it influenced the Welsh Government's £4.5m nosocomial investigation.
    e. it liaises with organisations within the Government, namely the Wales COVID-19 Evidence Centre, National Bereavement Steering Group, Community Health Councils, to obtain a better understanding of Welsh Government decision making;
    f. it has campaigned for patient privacy and the right not to be photographed for books and PR purposes when dying/deceased in NHS Wales hospitals;
    g. it has lobbied politicians, petitioned, made numerous visits to the Senedd and has carried out high profile media appearances including appearances on Question Time, BBC Politics Today, IPPO as well as many online and offline interviews;
    h. it is working towards establishing bereavement support working groups in health boards across Wales; and it has worked with the former First Minister for Wales and UK Government to ensure Wales gets parity with UK/England in the UK COVID-19 Inquiry;
    i. more recently, CBFJ Cymru has worked with the following organisations within the Welsh Government, namely: The National Bereavement Steering Group, as well as John Moss (Bereavement lead in the Welsh Government), to implement

bereavement support in hospitals; Heléna Herklots the Older People's Commissioner for Wales to lobby for change concerning DNACPRs, as well as the Wales Evidence Centre;

j. the group has lobbied and worked with all Welsh health boards in relation to bereavement support and to influence change and reform to their 'Putting Things Right' complaint process;

k. CBFJ Cymru has liaised with MS Mark Isherwood, Chair of the Cross Party Group on Hospices and Palliative Care in the Welsh Parliament, meeting with AFCP (Advance & Future Care Planning Strategy Group) on the 29/11/23 and has been liaising with Professor Mark Taubert, chair and national strategic lead of AFCP, to lobby for change in the DNACPR decision making process in Wales; an issue which is very much live in Module 6 and upon which CBFJ Cymru will be able to assist the Inquiry;

l. the Group has also liaised with Care Inspectorate Wales and Care Forum Wales.

m. CBFJ Cymru has lobbied the Welsh Government into implementing bereavement support within health care settings. We have made representation to the Welsh Government to investigate care home deaths and lobbied the Government to look at why patients during the first wave, with hospital acquired COVID-19, were discharged without testing. We also raised issues such as: the lack of staff testing (even those who were symptomatic) due to a shortage of tests; lack of sufficient levels of PPE and oxygen; and the facts that there was no requirement for the vaccination of health care workers.

77. CBFJ Cymru and I met with Heléna Herklots the Older People's Commissioner (OPC) for Wales to lobby for change concerning DNACPRs, care homes and complaint procedures on the; 6 October 2021; 16 December 2021; 4 April 2022; 26 April 2022; 11 August 2022; 16 September 2022; and 21 November 2022. CBFJ Cymru were pleased to see the steps taken by Heléna Herklots in voicing these issues. However, it is CBFJ Cymru's view that these steps should have been the norm in the first place. The fact they needed addressing shows a shocking lack of care and respect for older people's problems in Wales in the first place.

78. It is CBFJ Cymru's view that these meetings felt unproductive. The group acknowledges that the OPC appeared to actively engage with the discussion and showed genuine sympathy to what was conveyed throughout these meetings. However, this discussion felt wholly

unproductive. It is our position that the Welsh Government and the First Minister failed to heed any recommendation made to the OPC by CBFJ Cymru. We were particularly frustrated by the lack of response from CFW.

Lessons Learned and Recommendations

79. Throughout this witness statement, we have highlighted where the Welsh Government failed in its duty of care to the Welsh public and the care sector. The Welsh Government should have implemented the numerous recommendations which arose following the various research projects, exercises and reports that were carried out prior to the pandemic including but not limited to; Shipshape (2003); Exercise Taliesin (2009); Lessons learned from SARS: The experience of the Health Protection Agency (2006); Civil Emergencies in Wales report (2012). We believe that by ensuring adequate levels of RPE/PPE, appropriate testing capability, and suitable ventilation in care homes the impact of the pandemic on the care sector would have told a very different story to the one told here.

80. Improvements and changes must be made to procedures for discharging hospital patients to care homes. This would involve improving the interaction between Primary, secondary and tertiary care.

81. CBFJ Cymru believe that resilience should be built ahead of any future pandemic. This can be done in the following ways:
    a. ensuring the onshore production of Respiratory Protective Equipment/Protective Personal Equipment;
    b. the development of an in date and substantial stockpile of RPE/PPE;
    c. the development of a distribution network and supply chain for the provision of PPE to care homes;
    d. for PPE to be distributed to care homes regularly;
    e. by training care workers both domiciliary and those within care homes on the intricacies of PPE usage and IPC;
    f. through training and governance in respiratory viruses and infection control;
    g. ensuring that there is adequate morgue capacity in any future pandemic;
    h. palliative and end of life care.

82. CBFJ Cymru wants to ensure that there is improvement to and adequate integration between NHS Wales and social care. There should be a long-term policy for social care implemented as well as transparency and duty of candour in all areas.

83. The inclusion of non-paid carers among those with early access to vaccinations.

84. A unified approach towards decision making and the future implementation of guidance would serve to mitigate the wide disparities in care quality that many of our loved ones experience.

85. For the Welsh Government to take action to develop infrastructure and upgrade care homes with adequate ventilation to mitigate the risks posed by an airborne virus.

86. The development of a register containing the details of all care homes within Wales.

87. To develop guidance that would allow visitation of homes from family and loved ones when individuals have the correct forms mask and PPE.

88. Staff should receive daily LFT tests and frequent antigen testing, particularly when care home workers travel between numerous care homes and locations.

89. Care home staff must receive regular preparatory training in IPC measures. This training must be subject to formal assessment from an outside body such as CFW or CIW.

90. Staff must undergo improved training in end-of-life care. This should include training for the delivery of subcutaneous fluids and the use of syringe drivers to ensure adequate hydration and pain relief of residents being cared for at the end of their lives.

Statement of truth:

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Catherine EM Griffiths (Dec 6, 2024 12:30 GMT)

Dated: 06/12/24