Witness Name: Helen Louise Hough

Statement No.: 1

Exhibits: HLH/1 – HLH/20

Dated: 15 May 2025

UK COVID-19 INQUIRY – MODULE 6

WITNESS STATEMENT OF HELEN LOUISE HOUGH

I, Helen Louise Hough, make this statement as a member of the Covid-19 Bereaved Families for Justice Cymru. This statement is in response to the UK Covid-19 Inquiry's request for evidence under Rule 9 of the Inquiry Rules 2006 dated 25 March 2025 in respect of Module 6. The request sets out nine issues to be addressed in this statement, which I have responded to below.

Introduction - personal and professional circumstances and background

1. I met Vernon in 1972, when we were both 14 years old. We were married in 1981.

2. I trained as a nurse and then specialised in Midwifery. I became a district Midwife. Vernon was a very practical man, good with working with his hands. He could repair anything, and he worked as a mechanic in a local garage before becoming a mechanical fitter in a large local factory.

3. In 1987, we purchased I&S in Wrexham and converted it into a nursing home with 22 residents. In 1989, following a request to extend the premises from the County Inspectors, we extended the home enabling us to take in up to 40 residents. My sister, who is also a nurse, opened a nursery in the grounds of I&S. Initially we lived in a converted flat in the roof of I&S, but eventually we built a separate house on the grounds. We have always lived on site.

4. During this time, our families were quite involved with the nursing home. Vernon's dad took care of the garden. My mum, who was also a nurse, helped out in the nursing home and the nursery. And my sister also did some night shifts in the nursing home, when she was not in the nursery. It was a very happy, family run nursing home.

5. In 1992, Vernon was diagnosed with a brain tumour and following surgery, he became more involved in the nursing home as he could no longer work in the factory. We continued to work together until 2020, when Vernon died.

6. When we first opened in 1987, I worked full time as a nurse on duty. As I employed more staff and hired an administrator, my role changed. From about 2005 until 2020, I did three shifts every week but also covered any sick leave for our nursing staff. I also managed all aspects of the day to day running of the nursing home, including staffing, resourcing, purchasing (e.g., PPE and supplies), patient care and treatment, maintaining all clinical, building and other regulatory standards, engagement with relatives and families, and all liaison with the local health board, Betsi Cadwaladr (LHB), the local authority adult social services team within Wrexham County Borough Council, and Care Inspectorate Wales (CIW).

7. When I first opened I&S in 1987, there were four to five private nursing homes in the county of I&S. By early 2020, there were up to 40 adult care homes in the Wrexham area alone, all privately run. As an owner and manager of a nursing home, I regularly attended meetings with the local authority and their adult social services team, although most care home managers did not attend these meetings. I often raised issues that other managers may have felt unable to raise because they were worried about causing issues or problems for the owner of their care home.

8. I&S had a mix of patients and residents. When using these terms, I am referring to the same group of people, but the reference depends on the level of care they required. Some patients in I&S had complex health needs and required significant levels of nursing care. Most residents had a high dependency for nursing care, and only two or three could look after their own personal care needs (e.g., washing and personal hygiene). We had very few patients with dementia and sometimes had to arrange for their transfer to another care home or to a specialist elderly mentally infirm (EMI) home to ensure they received the care they needed.

9. In early 2020, our staffing comprised the following: 12 trained nursing staff, 35 carers (which increased to about 45 during holiday periods as we took on holiday cover for our staff), five domestics, two activity coordinators, two maintenance staff, five kitchen staff, one administrator, Vernon and me.

10. Vernon did all the maintenance. He also knew every resident and did the little things that meant a lot to them, like get their newspapers, take their watches for repair, put paintings and pictures up in their rooms, get them special orders from the shop - even fish and chips or a glass of sherry or whisky. He took them to his polytunnel to help do some planting with his dad, and he even pushed some residents in their wheelchairs up to the pub next door. Vernon went above and beyond to make sure that the residents were comfortable.

11. Vernon had a minibus, and he went with the staff on all the trips that the residents took. He brought them for their outpatient appointments, and he picked up and dropped off day-care patients. His involvement with patients and residents was daily. Residents loved him and whenever he was away, they wanted to know how long for or how soon he would be back. The atmosphere in the nursing home was always friendly, always happy.

12. For 34 years, our life and love was at I&S. We raised four children together - three boys and a girl. Eventually, Covid-19 took Vernon from me and our family.

Leading a care home during the Covid-19 pandemic

13. In late 2019, I began hearing about the virus that was in China. We had been through SARS previously and I thought it would be similar. We had been through avian flu, swine flu, outbreaks of norovirus, and the winter flu each year. We have had to close our doors in the past as part of infection control. There may have been some pandemic planning done for the care home sector prior to 2020, although I do not recall any specific planning and I do not have any details. Ultimately the sector was not prepared.

14. From December 2019, I started to stockpile disposables that were needed within the nursing home. I also began to stockpile PPE (I discuss PPE in more detail at paragraphs 70 to 80 below). By February, we knew that Covid was coming closer. Other countries were starting to lockdown. While I knew from my nursing training what we should do to prepare in the nursing home, as a country it seemed that there were no preparations. Even though we were all talking about Covid, we received little to no guidance or

communications from the Welsh Government, the LHB, the local authority or CIW, until we had a meeting on 10 March 2020.

Meeting with the local authority on 10 March 2020

15. On 10 March 2020, I attended a meeting at the Redwither Tower, Wrexham with representatives from Wrexham County Borough Council and GP cluster leads to discuss the impact of Covid-19 in the care home community. The meeting lasted over two hours, and I remember it being quite intense. I took notes during the meeting, which I subsequently rewrote to make sense of what I had recorded at the time. This included entering a date of 5 March 2020, as I could not remember the exact date until I found a message on my phone confirming it was 10 March. A copy of the notes I took during the meeting is exhibited to this statement as HLH/1 [INQ000598462]; the rewritten notes are exhibited as HLH/2 [INQ000598463]; and the screenshot confirming the date of the meeting as 10 March 2020 is exhibited as HLH/3 [INQ000598464].

16. The main speakers at the meeting were the heads of older peoples' services and adult social services at Wrexham County Borough Council and the GP cluster lead. The main thrust of the meeting was to discuss spotting the signs of Covid-19, treatment for the virus, how to reduce cross infection, and broader information about managing the outbreak. I recorded in the notes, 'face masks – not evident', which was a reference to being told that the benefit of using face masks was unclear. We were advised to follow the usual infection control procedures (see the section below from page 13 regarding infection prevention and control measures).

17. The approach seemed strange to me. We were instructed to clean surfaces after potential droplets from coughs and sneezes using a chlorine-based substance, which obviously recognised the dangers of infectious droplets. To then be told that there was inconclusive evidence to support wearing masks appeared to be completely at odds with these precautions.

18. The guidance that we distance ourselves by two metres from others was also unrealistic. We were unable to work with our patients and residents from this distance and, as a result, we were regularly coughed upon.

19. My meeting notes record that the majority of fatalities from Covid-19 would be in the over 80's age group, meaning that a large proportion of my residents and patients were at

highest risk. The advice given to us at the meeting was to 'plan for the worst, hope for the best!' I also made notes of what I thought were some very upsetting messages. These included:

a. Older people will not be ventilated.
b. The care home population will not be considered for ventilation (in fact, there were virtually no admissions from care homes into hospitals at all, even if a patient required hospital admission unrelated to Covid-19).
c. One GP will be allocated per care home with most consultations conducted over the phone (for our nursing home, no GP attended in person from March 2020 until well into 2021).

Testing

20. We were informed at the meeting that the testing of care home residents and staff would be managed by Public Health Wales (PHW) via their phone line, and it would be an appointment only system with test results being returned within 48 hours.

21. By this time, drive through testing centres had been set up across Wales including in the local village. I am not sure if these were operated by PHW or the LHB. Either way, we were sending staff to these testing centres if they had any signs or symptoms at all. Shortly after the meeting on 10 March, the drive through test centres disappeared suddenly with no apparent explanation. Testing became incredibly difficult after this time. I am now aware that the Welsh Government made a statement on 18 March 2020 (exhibited as HLH/4 [INQ000198641]) stating that "*Wales and the other UK nations have moved from the containment phase to the delay phase*", "*testing in Wales has been prioritised for individuals requiring admission to hospital*", and "*a phased rollout of testing will commence starting with health care workers involved in frontline patient facing clinical care*".

22. This statement also said that testing capacity was being expanded. However, we soon discovered there were no tests available in Wales. To begin with, you had to have 'symptoms' to get a test (which at this time were limited to only two symptoms – a temperature and a continuous cough) and then you had to go to England to get tested. At one time staff drove to Manchester Airport to be tested. Testing in Wales was totally inadequate.

23. If a patient required testing, we first had to ring the GP and then PHW to book a test. PHW or LHB staff came with a testing kit/swab for us to take the test. This took a minimum of 48

hours from ordering to receipt. Not one patient who passed away at I&S before 20 May 2020 had a Covid-19 test taken, even those who were showing signs and symptoms of Covid. By the time we got the test it was too late. I rang PHW several times asking for the whole team to be tested, and the answer was the same every time: the Welsh Government deemed it unnecessary to perform whole home testing of patients and staff. I discuss my engagement with the Welsh Government in relation to testing at paragraphs 96 to 111 below.

Do Not Attempt Resuscitation

24. During the week following the meeting with the LHB and GP cluster leads, some of the plans discussed began to be implemented. I discovered after coming back from another meeting that one Health Practice Group had started to put 'Do Not Attempt Resuscitation' (DNARs) on their patients. By the following week all GPs had put DNARs on their patients. This was in the run-up to lockdown on 23 March 2020.

25. We tried to contact each resident's relatives regarding the DNARs and advised them to speak to the GP if they had concerns about the DNAR staying in place. I am aware that the families of two patients managed to contact their GP questioning the need for the DNARs and subsequently the DNARs were removed.

26. I recognise that resuscitation is invasive and particularly for older patients, it might not be appropriate. However, these were decisions that should have been taken with the patient and their families following a discussion with their doctor. DNARs should not have been applied to each resident simply because they were in a care home. I do not know where this direction came from as we were simply sent the DNAR forms.

27. Even before the meeting on 10 March 2020, ambulance staff were asking whether DNARs were in place for patients to be transported. We had never been asked this previously and it applied even to patients being transported for outpatient appointments. Once we were in lockdown, ambulance staff refused to take a patient unless a DNAR was in place. They were very reticent to even enter the nursing home building and very reluctant to transfer any patient to hospital.

No admission from care home into hospital

28. As mentioned at paragraph 19b. above, there were virtually no admissions from care homes into hospitals, even if a patient required hospital admission unrelated to Covid-19.

29. On one occasion, we had a patient who had been admitted to hospital for an operation related to cancer treatment, but because the hospital was too busy, they came to us until a bed was available. They were diabetic and on insulin, and because of their cancer, their diabetes was unstable. One morning, the patient was drowsy with very low blood sugar levels, and we rang a GP who told us to ring for an ambulance. GPs were not attending care homes at this time, though they may have been able to administer intravenous glucose directly.

30. The ambulance team came and refused to take the patient to hospital because they had a temperature. My argument was that the temperature was clearly related to an infection caused by their illness, but the ambulance team would not take the patient. I felt helpless and rang the patient's family who spoke to the ambulance team. We had to wait while Ambulance Control got in touch with a doctor to approve the transfer. All the while the patient's blood glucose levels were dropping, and they were semi-conscious.

31. After three hours the ambulance team came back into the building. They told me the hospital was 'not going to be happy with us', as the ambulance team was not supposed to transport anyone from a care home, especially if they had a temperature. I remember saying 'it was not up to them to play God'. The patient's condition was so critical, they could have died. The patient concerned was admitted to hospital and returned to the home five days later, to wait for the operation later in the year.

32. I was insistent with ambulance teams that some patients needed to be transferred to hospital. For example, we had a patient who fell and suffered a fracture. Simply because they were resident in a care home did not mean that they should not receive the care they needed. In usual times, Vernon or a member of staff attended any patients in hospital and brought them food. We were always anxious if any patients were in hospital during the pandemic because we were not able to go to see them.

The policy of discharging patients from hospitals into care homes

33. From late February or early March 2020 (certainly before the meeting on 10 March), we were contacted by the LHB and the discharge coordinating team from the hospitals requesting that we accept patients from hospital specifically so that beds could be freed up. Patients were not routinely tested for Covid-19 before discharge from hospital to care home. However, I would not let anyone be admitted to our care home unless they had a negative Covid-19 test result, in writing. I was adamant that patients had to have a negative test before I would accept them. The response I had from the LHB was to the effect that I was going to be reported to CIW for 'bed blocking'. My response was that they could report me to whoever they wanted, but patients were not coming over the door to I&S without a negative test result.

34. What concerned me the most was the pressure being applied on other care home managers. As the owner, I had the right to refuse entry; however, managers or responsible individuals running other private homes may have had no authority to take this step and potentially infected patients were forced upon them bringing additional risk of infection to existing residents and to care home staff.

35. Usually, outside of the pandemic, we contacted the local authority and the discharge coordinators at the hospitals each week to let them know how many empty beds we had. This moved to daily once the pandemic started, so we started to receive patients from hospital, but as I said, only those who had tested negative.

36. I am aware that it was not until 15 April 2020 that the UK Government introduced testing for Covid-19 in England before discharge from hospital to care home. However, the Welsh Government did not adopt a similar policy until 29 April, two weeks later. This delay is indefensible.

Deaths of residents during the pandemic

37. Before the pandemic, we had a couple of deaths each month from natural causes. Many of our residents were very poorly and heavily dependent on nursing care, for example, if they were paralysed, required a feeding tube, had a serious stroke or had cancer. The number of deaths usually escalated during the winter because of flu or pneumonia.

38. When the practise of discharging patients from hospitals into care homes began in late February or early March, the number of deaths increased significantly because we were receiving patients who were already close to end of life. They had tested negative for Covid-19 (as I would only accept patients who had a negative test), but they were deteriorating rapidly and not expected to live for very long. We lost between five and eight patients in the weeks before lockdown.

39. I remember vividly our first Covid-19 death. The patient was a fit, mobile person in their early 90s, who had come in for respite whilst recovering from an operation. They had tested negative for Covid before admission (which I think was just after Easter 2020) and they had been with us for about three weeks.

40. I recall seeing the patient unsteady on their feet while walking from the bathroom one day. They told me they felt unwell and were going to lie down. This was a Wednesday.

41. We took their temperature, which was high, and informed their GP, who tried to conduct a zoom call to assess the patient, but the Wi-Fi was very poor in that part of the building. The GP prescribed antibiotics, which Vernon collected, and I asked the GP for a Covid swab to be taken. The GP had to contact PHW to request the test.

42. We started the antibiotics, but the patient's temperature did not come down. They began to complain of shortness of breath and started coughing. They did not want food, as 'everything was tasteless'. Their shortness of breath got worse, and their temperature continued to rise. I contacted a GP (a locum this time) and asked for oxygen for the patient - we had oximeters, and I knew their oxygen levels were low. I had to explain to the locum how to prescribe oxygen and by the time we got the prescription, it was evening and everywhere was shut.

43. We sat with the patient throughout the night and first thing the next morning Vernon ordered the O2. We also contacted the patient's GP to update, and I was told to start end-of-life drugs. I was surprised by this; I knew they needed oxygen. By the time the prescription for end-of-life drugs arrived and the paperwork was completed, it was late afternoon and the O2 had still not arrived.

44. We started the medication and that night the patient passed away in quite disturbing circumstances, struggling for air. It was a shockingly uncomfortable and distressing death.

They had no oxygen, which would have made the patient more comfortable. This was Thursday night.

45. I verified the death and stayed with the patient until the undertakers came. Our usual undertakers always treated residents with the utmost respect, and although their protocol had changed, they were still dignified in their treatment. They asked if the patient had been swabbed, but we were still waiting for the test. I asked whether they would undertake a test, but they said no as they had not been instructed to take one.

46. PHW brought a test kit on the Saturday morning, and I told them they were too late. I asked if I could use the test for someone else and was informed it could not be transferred, and it would have to be discarded. What a waste!

47. Although, this patient was never swabbed, we knew it was Covid-19 as their symptoms were so different from what we were used to, and we knew it was a Covid death. This was the first patient at I&S that showed symptoms of Covid-19. I am in no doubt that Covid-19 was brought into the home by a nurse or carer who was asymptomatic. It was the only way.

48. There were quite a few patient deaths from Covid after this – at least one resident a week with Covid symptoms, as well as normal deaths. Deaths from Covid were different to 'normal' deaths, with patients struggling to breathe. It was agonising and distressing for our patients, and their deaths had a significant impact on our staff and on Vernon.

49. We verified each death and reported it to the GP, having notified the GP and the patient's relatives in advance that they were deteriorating. When a patient became ill, we always notified the GP who tried to speak to the patient by phone or iPad and make a treatment decision based on their symptoms. The doctors could not see patients. If a patient's health was deteriorating or they were uncomfortable, the GP often prescribed end-of-life care.

50. I am not aware that there were particular difficulties for our undertakers during this period. They never raised any issues, for example around the supply of body bags. They always came in with one and they followed all procedures. As I said, they treated all our deceased patients with dignity. I believe emergency mortuaries were set-up, but I am not sure where they were.

51. None of the patients who passed away before 20 May 2020 were tested for Covid-19, and therefore their deaths could not be classified as a 'Covid-19' death. I do not know how many deaths were registered as a 'death with Covid' but I expect the actual figure for Wales is much, much higher. In a note written in May 2022, two years after Vernon's death and around the time of Welsh local elections (exhibited as HLH/5 [INQ000598466]), I recorded the following:

> "*For us to get a patient tested took between 36-48 hours, longer on a weekend, for anyone to even bring the swabs from Public Health Wales, to enable us to test a patient for COVID19, consequently by this time the patient had passed away, and therefore were not tested, so the Welsh Government figures for deaths in care homes, even though these were not counted in the figures for a very long time, were not accurate and are still not accurate. We lost 12 patients in those few weeks from lockdown on 23rd March until the Welsh Government decided to start testing in homes in May, none of whom were tested, so how many in Wales lost there [sic] lives because of not testing?*"

52. As a member of Covid-19 Bereaved Families for Justice Cymru supporting the group's engagement with the Inquiry, I have reviewed a document disclosed by the Inquiry from the Welsh Government, titled 'Covid-19 dashboard for adult care homes (as at: 06/04/2022)' (exhibited as HLH/6 [INQ000198645]). This document includes details of deaths notified to CIW by care home providers in Wales. In the tab titled 'Previous Years Notifications', it includes I&S notifications from I&S, the first dated 19 May 2020 indicating an outbreak on 16 May 2020 when three residents and three staff tested positive for Covid. This was the first time that testing was introduced for all residents and staff within the home.

53. Within the tab titled 'Adult Care Homes – Dashboard', from row 29, the monthly deaths of adult care home residents notified to CIW are shown in a graph. This graph indicates that in April 2020, the number of deaths (including Covid-19 deaths) more than doubled from the previous month - increasing from 596 in March 2020 to 1,231 deaths in April 2020. Only 107 of these deaths were confirmed Covid-19 cases (based on a positive test result). In May, only 175 of 836 deaths in care homes were confirmed Covid-19 cases. The tab titled 'Notifications of Deaths' shows that Covid-19 was suspected in at least 247 deaths in April, and 99 deaths in May. The report specifically notes that the information is only as accurate as the information submitted by the provider, so the number of suspected cases is very likely to have been even higher.

Our day to day and the impact on staff

54. Many of the staff worked double shifts and extra shifts, including the domestics, catering and administrative staff. Some stayed onsite - sleeping there until their days off, when they went back home. We had a caravan on site where staff could stay, which helped with reducing the chance of bringing Covid-19 into the nursing home. Staff worked over and above what was expected of them to ensure all the patients were well looked after and all their needs were met.

55. Many staff were furloughed as they lived with vulnerable family members, and luckily, we were able to replace these staff before lockdown. I did not use agency staff once we went into lockdown as I did not want staff going into different care homes or care environments and then coming into our nursing home. I did a lot of extra shifts to cover staff who had symptoms or were isolating. Again, I could take this decision as an owner/manager and as a nurse; other care homes may not have been able to cover staff absences without the support of agency staff.

56. Staff were frightened, not about catching Covid, but they were terrified of what they were potentially taking home to their families, or of passing it on to patients. Particularly after we lost our first patient with Covid, staff were terrified. Some staff felt they could not come back to work because it put their families at risk. The majority of staff were young women.

57. Vernon and I were working 16-hour days. We started our day at 07:30 am every day, earlier for me if someone had passed away during the night, as I would be involved in verifying the death (GPs did not certify deaths as they were not attending care homes at this time). It was also earlier for Vernon if there was a problem with the building, which there frequently was: a smoke detector going off, usually because of dust or cleaning sprays; a tap not turning off; a toilet leaking. We very rarely got a full night's sleep.

58. From 07:30 am, Vernon helped to feed some of the patients. Due to isolating patients in their own rooms, it took much longer to distribute meals to residents. He would put on his PPE (see further at paragraph 72 below) and give out some of the breakfasts; we each had our own patients to deal with. Vernon visited every patient every day, giving out newspapers, discussing topics, asking them if they fancied something special for tea (he would then go and get them what it was they wanted).

59. Vernon did the shopping for I&S, but because we were restricted in what we could buy, he had to start at the Cash & Carry and then queue in all the supermarkets to get the tinned food and other foods that we needed. One day he came back after queueing for two hours at B&Q to get a ballcock to fix a broken toilet.

60. Vernon helped out with lunches for the residents and then he generally had further maintenance to do. Every morning, he checked the maintenance books for any repairs that needed doing. There was always something to repair in a building as old and as big as ours. He also assisted with evening meals, and all this time, he did his best to reassure patients and staff that everything would be okay. It was a very difficult time.

61. Usually in the mornings, I was undertaking nursing duties or otherwise on the phone trying to get support for us from the authorities or trying to buy PPE. We felt very alone and isolated in those weeks. Although I took action – buying in PPE, refusing to accept patients from hospital without a negative test, and pushing for testing for our staff and patients – it felt like I was fighting the battle alone.

62. CIW sent a letter on 16 March 2020 (exhibited as HLH/7 [INQ000198575]) saying they would not do any inspections because of Covid, but I had weekly calls with them. They wanted to see how we were coping and asking if we were giving people activities! They did little to assist. Instead, we received reams of paper from the local authority, the LHB and CIW, with guidance and information that changed weekly. We had various forms to fill in to prove we were doing everything that needed to be done. I brought all this work home with me, because the priority during the day was nursing people but I felt swamped by what was being thrown at us. I recognise it is important to record what was being done and to make sure everything was being done appropriately; however, the amount of paperwork we were sent did not make anything better. I felt that there was no comprehension on the part of the local authority, the LHB or CIW as to what we were dealing with on a day to day basis. We were so busy, all the time. And when we started to lose patients, it was devastating for all of us.

Infection prevention and control measures

63. We implemented infection control as best we could. Much of this was based on my nursing training and existing knowledge of effective infection prevention and control measures (as we would apply for MRSA or norovirus, and as we adopted for swine flu). In early 2020, no one was telling us what we should do to manage an outbreak, but we did it ourselves.

We split the nursing home into three sections or zones, and we divided the staff into groups, so the same staff worked in the same 'zones' when on duty. We believe this helped reduce infection; however, it was difficult to keep going. If any staff had signs or symptoms of Covid, they could not come to work and another staff member would have to cover – ideally from their own team, but otherwise someone had to be pulled from another team. Some staff were furloughed to protect vulnerable family members. And a huge problem related to childcare – if a school could not take in children (because they closed or they were short a teacher), then our staff had no childcare and could not come to work. I remember writing to one school because they would not accept the children of two staff members on the basis that they were not key workers.

64. Zones were designated green or red, and the red zone was for patients who showed symptoms of Covid. This reduced movement of staff from a red zone into a green zone (only Vernon and I crossed over zones because we could change our clothes). We never ran out of beds in the red zone, and it was more likely that we had beds empty. After a patient moved out of a room, it was kept empty for 24-48 hours and sterilised using a specialist ozone, sterilising machine.

65. If members of staff showed the slightest cough, they did not come into work (or later, if they could not smell). When lockdown one was first implemented, it was 'Hay Fever' season, and many members of staff could not come to work as we did not know whether they were suffering from allergies or Covid infection. We asked them to get a test done, and they stayed off work until they had a negative swab. At one point we had 15 staff isolating, trying to get tested so they could come back to work, but there were no available tests. This added to the pressures on other staff who worked around the clock to support residents.

66. If staff tested positive, they were out of work for two weeks. This was very difficult for some staff as they could not be placed on furlough for being sick. In one case, a staff member continued to test positive after the two weeks, and we were told by PHW that they should come back to work as they were no longer infectious. That was terrifying for me and for the member of staff, and they stayed in full PPE at all times.

67. We had indoor and outdoor areas for the staff, and a 'dirty' changing room so they could change out of their work clothes, leave them at the nursing home for laundry, and return to their own homes in clean clothes. I am aware that one nursing home set up a tent

outside so the staff could shower and change clothes before coming into the home and when they were leaving.

68. We wiped down all our surfaces, and every letter and box were cleaned.

69. We kept I&S well-ventilated and during the first wave, the only door in the building that was closed was the front door. Every window was open, and we had a constant flow through of air. The building did not have a ventilation system, and we did not have HEPA filters. In fact, there was never any discussion around HEPA filters within the care home sector – whether before the pandemic or in early 2020. As I said above, generally the sector was not at all prepared for an airborne pandemic. By winter, we knew that ventilation was crucial, but we could not keep doors and windows wide open. By this time, patients could come to the communal areas and socially distance. While they were away, we ventilated their rooms. We sterilised communal areas using the ozone machine every evening.

Personal protective equipment (PPE)

70. As a nursing home we would generally have a supply of PPE but not in significant volumes. As mentioned at paragraph 13 above, from December 2019, I began to stockpile PPE and other disposables needed for the nursing home. We had to close the nursing home doors in response to previous outbreaks (such as swine flu and sometimes, seasonal flu) and I knew that PPE goes very quickly.

71. As nurses, we practise 'barrier nursing' to prevent the spread of infection (e.g., MRSA) from one patient to another, or from patients to healthcare staff. When we do dressings for example, we need a sterile area, and we use PPE a lot. We are trained in how to don and doff PPE, as it is important how PPE is removed. The nurses at I&S trained all carers in the correct procedures for removing PPE. This may not have been the same in every care home. The Welsh Government issued a training video on how to remove PPE (I think this was sometime in April 2020, but I cannot be sure); before this I am unsure that all carers and nursing home staff would have known how to do it properly.

72. We already used surgical masks, plastic aprons and gloves and we had our own suppliers. However, the full PPE pack – theatre gowns, visors, hoods – was new. It became impossible to buy disposable gowns, so we had to make them.

73. Around late February/early March, one of my regular providers of PPE refused an order and I was told they could only supply to England. I was totally taken aback and contacted the owner who I had supported with regular orders since the company was set up. He overruled this and sent me the items I was looking for. However, they were not supplying to any other care homes in Wales. I remember other care homes ringing and asking if we were having difficulties with supplies.

74. I bought a lot of other PPE mainly from Amazon or DIY shops – plastic festival ponchos, painters overalls, gloves. I have exhibited to this statement as HLH/8 [INQ000598469] a photograph of Vernon in his PPE showing the best we could get from our local DIY store. I do not recall the date that this was taken but we were receiving little help from the local authority at this time.

75. The PPE provided by the local authority consisted of surgical masks, plastic aprons and gloves. However, we got full theatre gowns, hats, arm coverings and thicker cloth masks made for us by local people and the relatives of staff. They made isolation gowns out of old duvet covers and these were worn when any patient showed any Covid-19 signs. These 'theatre' gowns had to be changed every time you entered a room, so we could go through 20-30 gowns a day on a 'barrier nursed' patient.

76. I cannot remember the first date that the local authority provided PPE, although it was definitely in April 2020. I am aware that some local authorities started distributing it before Wrexham. We had to drive to collect the PPE, and we were restricted in how much we could have. We collected PPE weekly from the local authority. Thankfully, we never ran out of PPE, and we kept up our stocks. However, in the queue to collect PPE, other services were reporting they did not have enough.

77. At one point the local authority gave us 600 goggles. They did not fit women and, as most of our workforce was female, Vernon drilled holes in every pair so that we could put elastic around them to try to make them more secure. Within a month we were told not to use the goggles because they did not fit. The local authority gave us nothing as a replacement, although a month or so later we were given visors. We already had visors in the home because a local factory had made visors for us.

78. We were not provided with FFP3 respirators, but I bought them (at great cost) from Amazon. If we thought a patient had Covid-19 (for example, because they had a temperature), we wore an FFP3 respirator instead of a surgical mask. As nurses, we knew

a surgical mask would not protect us. They do not fit your face, there are gaps at the side, and they are designed to stop the wearer coughing or passing infection to a patient. They do not prevent a healthcare worker from catching infection from a patient by inhaling infectious aerosols, which is why I was asking for FFP3. I knew nurses in intensive care and critical care wards were receiving FFP3, although healthcare workers looking after Covid patients outside of these areas (and outside of Aerosol Generating Procedures) were not given FFP3. In care homes and nursing homes, we were not provided with FFP3. As Covid-19 was an unknown, I bought FFP3 and we wore them as a precaution (irrespective of the requirements in the IPC guidance).

79. The cost of PPE had a huge financial impact on the business. For example, a box of 100 pairs of gloves before the pandemic cost £1.79; this increased to £5.00 per box once the pandemic started (and up to £10 per box from Amazon for only 50 pairs of gloves). FFP3 masks also increased dramatically in price. We went through thousands of items of PPE - aprons, gloves, gowns, masks. As I said, I was buying what I could from Amazon particularly around the end of April/beginning of May. This was to prop up what was being provided by the local authority. Our spend on PPE increased at least three-fold and likely more. Our clinical waste, which was another expense, also doubled. We had alcohol gel around the care home before the pandemic, and we moved to every carer having their own alcohol gel on a clip. Although not PPE, the copious amounts of alcohol gel that we needed added to our costs.

80. Wearing PPE was very difficult as patients struggled to hear us with masks on. Visors steamed up, particularly if you wore glasses (as Vernon and I did). Our patients were not required to wear masks, but they were offered a mask in communal areas. Many of our patients preferred to wear a mask when they were out of their rooms.

Restrictions on residents and their impact

81. Although lockdown started on 23 March, from the very outset of Covid-19 being of concern, we ensured residents were isolated in their rooms if they presented with any symptom (for example, a temperature). By early April, all residents were in their rooms as it was impossible to keep (our few) mobile patients with dementia confined, so instead of risking the spreading of Covid to other patients, it was safer for them all to be in their own rooms.

82. Many of our residents did not like being confined to their own rooms. However, with the televisions broadcasting information regarding Covid-19, they understood the necessity and they did not complain too much.

83. If a patient developed symptoms we moved them to a room in the red zone within the home. However, patients did not like moving bedrooms. For many, the nursing home was their home, and their bedrooms were more than a bed in a hospital. Many residents lived with us for years and they did not want to move bedrooms. Particularly after testing was introduced and residents tested positive but had no symptoms, it became more difficult to move them. Patients viewed the red zone as where people passed away – I can only recall two patients who recovered from Covid and were moved back into a green zone. If a patient was asymptomatic, we quarantined them in their own room. It was only when they had symptoms that we moved them to the red zone. Isolating a patient in their own room meant an increase in the PPE required, as every time a nurse or carer went into the room, they had to change into full PPE and FFP3.

84. The restrictions made providing care more difficult and time consuming, as we had to go into each resident's room, rather than attending them in communal areas. This included mealtimes, administering medications or taking their temperature, which was done three times daily.

85. Residents were, of course, very frightened. We advised relatives to provide mobile phones for residents so they could ring them and speak to them in their rooms. The activities co-ordinator visited every patient, every day. On her days off, she recruited a carer or domestic to carry out her role, but it was still very difficult to reassure worried residents.

86. That said, the morale of patients and residents was kept relatively high considering what was going on in the outside world. Gradually patients could come out of their rooms although many of them preferred to stay in there, feeling safer. It was their choice. Because of this, if they did come out of their rooms, they were well spaced out leaving plenty of room between each other.

87. We rearranged the dining room and lounge by opening up the double doors between the two rooms to create a large lounge area, with comfortable chairs spaced out around the area and plenty of room between each patient. Games of Bingo and quizzes could still take place. Staff put on a VE Day show outside for the patients, so they could all see through their windows and join in with the singing. All these extra things could not be

'measured'. At this time, we had lost our first patient to Covid-19, but staff still went above and beyond, whilst grieving themselves. We were an extended family and losing patients in this manner was distressing for everyone.

Visiting restrictions and technology

88. In the early days relatives could still come and visit and 'chat' through the many windows and doors we had, although the majority of relatives did not want to visit. Many were frightened to come, partly because they did not want to risk giving anything to their family member and partly because they did not want to catch anything themselves.

89. No GP entered the building after 23 March to administer to a patient until well into 2021. Any interaction between the GP and patient was done via 'Facetime'. We had no oxygen in the building, even though everyone knew that oxygen relieved some of the stress on the airways. It was an apparent safety measure that we were not allowed to keep O2 onsite unless it was prescribed for someone. I argued this with the LHB, CIW and the local authority social services (all government bodies) as well as local GPs. We were never given any that we could have on standby. If oxygen was prescribed, it was measured by the box for use by a single patient (as opposed to an oxygen cylinder that could have been used for more than one patient). Ambulances always had oxygen and if an ambulance team came into the care home, often the first thing they did was administer oxygen. The relief that it gave was remarkable. I recall one occasion when the improvement in the patient was so great after receiving oxygen, that they did not have to be taken to hospital.

90. The internet signal in the hall was very poor as the walls were very thick, and although we had boosters everywhere, as well as two broadband systems, the calls often broke up or froze, making contact with the GP very difficult.

91. Tragically, the poor internet signal also impacted on our interaction with relatives when a patient/resident was dying. I do not have the words to describe how horrendous that was for everyone. We lost connections a lot, which was just not right at such a difficult time. Unfortunately, we could not risk allowing workmen into the building to try to improve it.

92. The lack of visitor access also meant we spent a lot of time trying to ensure that family members could reach the residents on zoom calls.

93. In between the first lockdown and the second lockdown, we made an 'atrium type' visiting booth in one of the lounges, whereby visitors could come inside through patio doors and be inside of a booth and we could wheel patients up to the booth so they could have private chats with their relatives without being in any danger to each other.

94. This was my husband's idea. He started to make it in the first lockdown, but he did not get to finish it. Our handyman finished it, and it worked very well.

95. Prior to Covid-19, the district nursing team usually visited the residents in the home (as opposed to those designated as 'patients' requiring nursing case). We were reluctant to allow nurses to come in, particularly when they may have been attending other care homes. We agreed to keep the district nurses updated on what we were doing for residents, but they did not cross the threshold once the pandemic started.

Testing within the Care Home

96. As I said above, all patients coming into my care home were tested and all staff that had any symptoms of Covid stayed home until they had a negative test. After our first Covid death, I knew that Covid must be being transmitted through asymptomatic staff. All patients had their own rooms, and they were not spreading it among themselves.

97. On Friday, 1 May 2020, probably around the time that we had our first Covid death, I emailed Lesley Griffiths AM, who was my local Assembly Member and Minister for Rural Affairs and North Wales within the Welsh Government (exhibited as HLH/9 [INQ000598470]). The email was copied to Sarah Atherton MP as the MP for Wrexham.

98. My email, while directed to Lesley Griffiths, was intended for the First Minister, Mark Drakeford. I requested that Lesley pass the message to the First Minister. I was very disappointed that the First Minister had made the decision not to test residents and staff in care homes for Covid-19, unless they were symptomatic, having stated he was following 'scientific advice' (it should be noted that three days previously, on 28 April 2020, the UK Government had announced the expansion of testing to all staff and residents within care homes in England, whether they had symptoms or not). I wrote the following in my email:

> "*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.

…

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".

99. I believe that after the Prime Minster implemented testing in care homes, I rang PHW, and they agreed that testing could be done. However, it was later that same week that the Welsh Government, on the Friday, said 'the resources would be better spent elsewhere' prompting my email.

100. I received a response from a member of Lesley Griffiths team on 4 May 2020, which included a copy of the written statement on Coronavirus testing in care homes dated 2 May 2020 by Vaughan Gething AM, the Health and Social Services Minister (exhibited as HLH/10 [INQ000182440]).

101. I was already aware of this statement by Vaughan Gething and how it, in my opinion, was not addressing the issues. I responded to the email from Lesley Griffiths' team the same day (exhibited as HLH/11 [INQ000598472]).

102. In my response email I raised three very specific issues that were resulting in the death of residents without being tested. First, the time taken to swab a resident was too long, and patients died before they could be tested, meaning the swab was wasted and the figures were skewed. Secondly, there were no oxygen facilities onsite following a decision

a few years previously that oxygen had to be prescribed and could not be held in stock even for emergencies. When we asked GPs to prescribe oxygen, we were often given end of life drugs instead. I wrote: "*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*".

103. Thirdly, scientists understood that some people were asymptomatic but nevertheless had Covid-19, meaning there was a real concern that staff, coming into the home every day, risked bringing in the disease. I wrote:

> "*Nine miles down the road, all the staff and residents are being tested, because our Prime Minister has seen the urgency in this and can see the consequences of not testing, but the Welsh Government has decided not to do this, even though there are more (true) deaths happening in the Social care sector in Wales than in the NHS…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…*"

104. I received a response the same day informing me that Lesley Griffiths was concerned to have read my email and had forwarded my email to both the First Minister and the Minister for Health and Social Services for their considerations. It was a considerable time before I received a proper response.

105. On 6 May 2020, I emailed Sarah Atherton MP again as I had not had a response to my email of 1 May that she had been copied into. I received a response soon afterwards and she wrote: "*I can't comment without it sounding like political-point scoring but suffice it to say that I agree with you 100% and have been saying as much to Ministers*" (exhibited as HLH/12 [INQ000598473]).

106. I received a further email from Sarah Atherton MP on 11 May 2020 where she agreed that testing should have been extended to care home staff and residents from the beginning and noted that the Welsh Government was coming around to this way of thinking (exhibited as HLH/13 [INQ000598474]). I responded the same day and wrote the following (exhibited as HLH/14 [INQ000598475]):

"*My staff are really frightened here without being able to get tested we don't know what we are nursing. I have taken the precaution of all the residents staying in their room, which is horrible for them, and are advising the staff to get postal swabs and 'fib' on the forms about having symptoms. We really shouldn't be expecting these very caring Key Staff to be having to do this. An army [mobile] unit should be outside my building, testing everyone, every week, to stop this epidemic in [care] homes*".

107. It was not until 16 May 2020, that Vaughan Gething announced that testing would be expanded so that staff and residents in all care homes in Wales could be tested regardless of symptoms. This was 18 days after the expansion of testing in England was announced. Again, this delay by the Welsh Government is indefensible.

108. Before this announcement and throughout early May, I was raising the issue with PHW regularly, questioning how bizarre it was that the army was less than 10 miles away, doing all the swabs in homes weekly, but I could not get any tests for my patients, who were dying in horrible circumstances. Eventually, PHW agreed that we could do the swabs if we took them all ourselves and sent them off, but I was told, "*I was not to expect this again*". I remember saying to PHW on the telephone that it sounded like they were doing us a favour, to which they said they were.

109. On 19 May 2020, I emailed Lesley Griffiths' team (exhibited as HLH/15 [INQ000598476]) informing that on 16 May, after weeks of arguing with PHW following the loss of so many lives in our care home, we were eventually able to test staff and patients – the same day the Welsh Government announced the expansion of testing in care homes. Testing was undertaken jointly by staff in the care home (testing patients) and a team from either PHW or the LHB who tested staff in a caravan set up on the grounds. Testing was completed in under one hour. By the time of my email, we had received some of the results back, confirming that three residents and two members of staff had tested positive with no symptoms. A third member of staff subsequently tested positive (as shown in the notification to CIW referred to at paragraph 52 above). These results highlighted the importance of weekly testing of all staff and patients.

110. I received a response from Lesley Griffiths' team the same day informing me that the results of testing in my care home had been shared with the First Minister and the Minister for Health and Social Care, and that Lesley Griffiths had "*reiterated to them the reasons why Nursing and Care Homes wanted weekly testing of staff and patients*" (exhibited as

HLH/16 [INQ000598477]). I was also supplied with a copy of the latest written statement by the minister for Health and Social Care's statement dated 16 May 2020 (exhibited as HLH/17 [INQ000182446]).

111. While the measures announced on 16 May were welcomed, there is no explanation for why they were not introduced on 28 April at the same time that testing was expanded to all care home staff and patients in England. The science was the same between England and Wales. In my view this was nothing short of party-political point scoring. Had testing been in place from this date in April, we would have had a chance at preventing the transmission of Covid-19 to some of our residents, a number of whom sadly passed away with Covid-19 symptoms before they could be tested.

The circumstances surrounding Vernon's death

112. I began to notice that Vernon was losing weight. He said it was not surprising as he did not have time to eat. I told my daughter that I was worried about him, and she called in to see him. She sat outside and he sat inside with the door open. She told him that he may need to speak to someone, and his answer was, "*who? A screen or a computer?*" My daughter rang me because she was quite bothered by his answer.

113. We carried on working hard every day, with me arguing with people on the phone every day trying to get support. I started writing to the Welsh Government because at a local level nobody was doing anything. As I mentioned at paragraph 99 above, at one point, PHW agreed to do testing in the home, but then the Welsh Government changed what the Prime Minister had said, and they refused to do it. Vernon saw this and possibly felt that we were getting nowhere.

114. I have exhibited a photograph of Vernon and me in our masks as HLH/18 [INQ000598479]. This was taken by a member of staff on Wednesday 20 May 2020, the day before Vernon died. The staff member had joked that we must have been talking about something very serious as we were sitting very close together. We were. Vernon was by this time very stressed and distressed due to the continuing deaths of our lovely residents, some of whom we had nursed for a long time. They were dying without any real medical help. I told Vernon that no matter what, we would go away at the end of June to give him a very needed break.

115. We carried on working that evening until about 10:00pm – Vernon with his tasks, and me with mine. I remember Vernon going up to bed but coming down shortly after, questioning how we could possibly get away for a break. I remember him saying he could not see an end to it. I tried to reassure him, but I guess it was not enough.

116. The next morning, he was up and showered before me. I did not really see him as we were working in different areas. I noticed the car had gone so assumed he had gone shopping. I must admit, I did have a strange feeling as I could not get hold of him on the phone. I came home to look for him, and saw his phone and wallet were both still there. More strangely, so was the dog. He never went anywhere without the dog.

117. I was in my home office waiting for the computer to boot up when a policeman entered, asking if I was Vernon's wife. He asked if I was alone, and I knew then that something was tragically wrong. I was told that Vernon had been found slumped in his car outside the local Police Station. It appeared he had taken his own life.

Long-term impact

118. When I was told about Vernon's death, the police warned me that the press would get wind of it and advised me to contact my family immediately. The press hounded us, ringing the home or turning up, trying to get us to talk. It was all over the news and in every local newspaper. Vernon's Facebook profile picture was suddenly everywhere. I was bombarded on messenger by journalists. I remember I just happened to post a birthday greeting to a friend on Facebook and was very quickly contacted by the media asking questions. I had to turn it all off. Even now, I very rarely post anything publicly. Vernon's inquest took place in October 2020, and the press were there, secretly filming me as I went into the inquest. It was on the news that evening.

119. It was a very difficult time for us as a family. Vernon's death had an impact on everyone – me, our children, my mother who Vernon visited every day, and all our patients and staff.

120. About a year after Vernon's death, I agreed to an interview with ITV Wales because, even though I had sold the nursing home by this time, I felt that nothing had changed in terms of Welsh Government decision-making and party-political point scoring. My mother had recently gone into hospital following a fall, and the hospital was locked down for two weeks. We were undertaking lateral flow tests daily, and other hospital and care settings were open (including **I&S** which held a garden party), but I was unable to visit

my mother in hospital for two weeks. There was no consistency in the decisions being taken. I felt compelled to speak out and it prompted me to agree to the ITV Wales interview and radio interviews so that I could highlight these issues.

121. On 1 July 2020, I received an email from Lesley Griffiths' team, attaching a letter from Lesley Griffiths and a copy of a letter to her from Julie Morgan AS/MS, Deputy Minister for Health and Social Care dated 30 June 2020. The letter from Julie Morgan is exhibited as HLH/19 [INQ000598480]. Both letters only addressed what was, by then, common knowledge of the testing process in care homes since 16 May 2020. I responded on 9 July 2020 informing Lesley Griffiths of Vernon's death and wrote: "*'Stable doors and bolted horses' springs to mind*". I received responses of sympathy, but this was all too late, not only for Vernon, but a large number of our residents as well.

122. Around this time, I put our lovely nursing home on the market. We had run a good, kind, family nursing home, but it all became too much for me and my family.

123. I do not know the exact date, but I believe it was late December 2021, following the announcement of the Scottish Covid-19 Inquiry, that I wrote again to Lesley Griffiths explaining the feelings of helplessness that Vernon experienced leading up to his death because of the lack of testing. I raised my concerns that Wales was not having its own Wales specific Covid inquiry, as decisions made in Wales should be scrutinised in Wales. A copy of this letter is exhibited as HLH/20 [INQ000598481]. I do not think I ever received a response.

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.

Signature:

Personal Data

Name: Helen Louise Hough

Date: 15 May 2025

Appendix – Exhibits

Exhibit Ref	Date	Description	Inquiry Ref
HLH/001	Undated	Handwritten notes taken during meeting with Wrexham County Borough Council Adult Social Services and GP cluster leads on 10 March 2020	INQ000598462
HLH/002	?5 March 2020	Re-written notes from meeting with Wrexham County Borough Council Adult Social Services and GP cluster leads on 10 March 2020	INQ000598463
HLH/003	10 March 2020	Screenshot of Covid-19 meeting on 10 March 2020	INQ000598464
HLH/004	18 March 2020	Written statement by Vaughan Gething titled, 'Coronavirus (COVID-19) – Testing'	INQ000198641
HLH/005	21 May 2022	Note created two years after Vernon's death about our experience during the pandemic	INQ000598466
HLH/006	6 April 2022	Notifications of Covid-19 cases in Registered Services, notified to Care Inspectorate Wales	INQ000198645
HLH/007	16 March 2020	Letter from CIW re: response to Coronavirus	INQ000198575
HLH/008	Undated	Image: Vernon in PPE	INQ000598469
HLH/009	1 May 2020	Email from HLH to Lesley Griffiths (AM). Subject 'Testing in Care Homes Wales. Cc; Sarah Atherton (MP)	INQ000598470
HLH/010	2 May 2020	Written statement of Vaughan Gething titled, 'Coronavirus testing in care homes'	INQ000182440
HLH/011	4 May 2020	Email response from HLH to LM	INQ000598472
HLH/012	6 May 2020	Email from Sarah Atherton to HLH	INQ000598473
HLH/013	11 May 2020	Email from S Atherton to H L Hough	INQ000598474
HLH/014	11 May 2020	Email response from H L Hough to S Atherton	INQ000598475

HLH/015	19 May 2020	Email from HLH to LM and SA following testing in her care home on 16 May 2020	INQ000598476
HLH/016	19 May 2020	Email response from LM to HLH attaching a copy of statement by VG dated 16 May 2020	INQ000598477
HLH/017	16 May 2020	Written statement by Vaughan Gething titled, 'Covid19 Testing in Care Homes Update'	INQ000182446
HLH/018	20 May 2020	Image: Vernon & me	INQ000598479
HLH/019	30 June 2020	Letter from Julie Morgan (AS/MS) to LG (AM) response to letter dated 4 May 2020 to First Minister (MD) and Min for Health (VG)	INQ000598480
HLH/020	Undated	Undated letter from HLH to LG postdates a letter sent to MD dated 31 August 2021.	INQ000598481