COVID 19 INQUIRY

MODULE 5:

PPE AND PROCUREMENT

WRITTEN CLOSING STATEMENT

OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU

INTRODUCTION

1) From 3 to 27 March 2025, the Inquiry heard evidence on 'Procurement and distribution of key healthcare equipment and supplies' (Module 5). Of the 48 witnesses who attended to give evidence, just four gave evidence on issues specific to Wales: Alan Brace, Andrew Slade, Jonathan Irvine and Richard Davis. Their evidence lasted just over 4 hours. CBFJ Cymru was allocated a total of 40 minutes to question them. Of course, the evidence of some of the remaining 38 witnesses touched on the devolved administrations. But not in any detail. And CBFJC was permitted questions of just two of the 38 - Rosemary Gallagher (RCN) and Matt Hancock - for a total of just 10 minutes. Crucially, and notwithstanding the requests of CBFJ Cymru, at no stage did the Inquiry hear from the former First Minister, the Rt Hon Mark Drakeford, nor Mr Vaughan Gething, the Minister for Health and Social Care in Wales over the majority of the relevant period (Jan 2020-May 2021) who had ultimate responsibility to ensure healthcare workers and the people of Wales had the PPE and healthcare equipment they needed.

2) In such circumstances, it is inevitable that gaps remain in the Inquiry's understanding of the issues faced in Wales with respect to procurement and distribution of PPE and other key healthcare equipment. That gaps remain in the Inquiry's understanding is not a criticism of the Chair: in the time available, there could be no realistic hope of unpacking the nature and extent of the failures in Wales. But the point nevertheless remains: if there is at best only a partial understanding of failures in Wales, how can the CBFJ Cymru, their members, and the people of Wales more widely, have any confidence the Welsh Government will reflect on its failures and learn lessons for the future?

3) The issue of 'lessons learned' and recommendations are addressed in more detail at the end of these closing submissions. In these introductory remarks, we note the CBFJ

Cymru's concerns as to recommendations and lessons learned. The signs are ominous for Wales. The evidence of the Welsh witnesses – both orally and in writing – appears to reflect the belief among those in positions of responsibility in Wales that the roots of their problems lie beyond the Welsh borders, either in Westminster or further afield. The CBFJ Cymru are concerned that there has been little reflection, let alone constructive criticism, of what went wrong in Wales.

4) The Inquiry should not be taken in by statements that Wales did not experience the same problems as England. Such statements have the regrettable appearance of self-congratulation. Nor should it be taken in by statements extolling the virtues of small governance. Such statements have the regrettable appearance of idealism: in reality, as we have seen, "small" does not necessarily translate to good, effective and efficient governance.

5) Against that background, some (not all) of the most problematic issues – and problematic gaps in understanding – are addressed below in these closing submissions.
    a) Pandemic stockpiles
    b) PPE and equipment in hospitals
    c) PPE and equipment in care homes
    d) Ventilators, oxygen and CPAP (other equipment)
    e) IPC Guidance on FFP3 masks
    f) Lessons learned
    g) Conclusion

PANDEMIC STOCKPILES

Introduction

6) After some introductory remarks, this section on Wales' 'pandemic stockpile' covers:
    a) The failure to implement the recommendations of exercises
    b) Extent of the deficiencies: comparisons with the other UK nations
    c) Addressing the deficiencies: Just-In-Time contracts and re-testing of FFP3 masks
    d) Reasons for deficiencies in the Wales' stockpile
    e) Conclusion

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

8) The Wales stockpile was not adequate to respond to the Covid 19 pandemic.

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

10) It is important to note at the outset that the stockpile was the responsibility of the Welsh Government. Witnesses who gave evidence to the Inquiry appeared to show worrying confusion over this important point. Mr Brace (Welsh Government) suggested it was the responsibility of the NHS Wales Shared Services Partnership ("NWSSP") to ensure stock was monitored and fit for purpose [Brace; 6/180/17]. In other respects, he suggested it was the responsibility of the UK Government: the "plan for the PIPP stockpile was the responsibility of the UK government" [Brace; 6/191/13]; when the stockpile was down to 4 weeks, his "biggest concern was about getting clarity and assurance from the UK government they could fulfil their obligations under the emergency plan, and that proved exceptionally difficult…" [Brace; 6/191/1-8]. By contrast, Mr Irvine, director of procurement at NWSSP, understood that the stockpile was the responsibility of the Welsh Government [Irvine; 14/109/10-14/111/8]. This is consistent with the evidence of Mr Hancock, who reminded the Inquiry when asked specifically about the responsibility for the Welsh stockpile, that health was a devolved matter and the stockpile was accordingly the responsibility of the Welsh Government [Hancock;11/145/13].

11) The Wales stockpile was seriously deficient in the following ways:
    a) The quantities of stock held were woefully inadequate to withstand a pandemic.
    b) The stockpile had not been maintained and significant quantities of the equipment held within the stockpile was out of date, particularly FFP3 respirators.
    c) The plan to supplement the stockpile through Just-in-Time contracts was flawed, and these arrangements collapsed in the face of global competition,

which the CBFJ Cymru submits was entirely predictable and ought to have been foreseen.

The failure to implement the recommendations of exercises

12) Between 14 and 20 October 2014, the Welsh Government conducted a pandemic flu exercise, Exercise Cygnus, and in October 2016 produced a report, "Exercise Cygnus – Wales De-Brief Report" [INQ000187149_0001].[1] It is to be noted that NWSSP had been in operation for some years by this stage (since 2011).

13) This report contains the following objectives, observations and recommendations:
    a) "The workshop considered what countermeasures would be made available from the national stockpile and the mechanisms for distribution across the NHS in Wales and the mechanisms for local distribution across the NHS in Wales. The morning session...raised awareness of the consumables, antivirals and antibiotics held in the national stockpile. In the afternoon, delegates had the opportunity to work through the Cygnus scenario and were able to explore the national and local arrangements for each of the countermeasures...It was acknowledged that once a pandemic is threatened, the operational details to secure effective and efficient distribution across Wales would be quickly put into place." [INQ000187149_0003]
    b) Objectives for the day included:
        i) "To explain why particular products are held within the national stockpile"; and
        ii) To explain the National planning arrangements for storage and deployment." [INQ000187149_0003]
    c) Recommendation 2 - "All organisations to ensure there is sufficient awareness within their organisations of what is held within the Welsh National Stockpile and how these would be distributed to them." [INQ000187149_0004]

14) Despite this focus in Exercise Cygnus on the Welsh National Stockpile and the awareness of its importance, much of the stock of FFP3 respirators held within the stockpile had expired. The stocktake of the Welsh National Stockpile performed in February 2020 [INQ000300270] records that out of a total number of 929,600 FFP3

[1] Document disclosed in Module 1

respirators held in the Welsh stockpile at the outset of the pandemic, only 59,600 (less than 7%) were in date.

15) This out-of-date stock was comprised of two groups of stock with expiry dates of 13 October 2016 and 1 August 2019, a position that was regularly reported to and known by the Welsh Government, as confirmed by Jonathan Irvine of NWSSP in his oral evidence to the Inquiry [Irvine; 14/111/1-24].

16) The cost of the FFP3 respirator stock held in the stockpile was £1,764,920 (as recorded within INQ000300270) and while not an insignificant sum, CBFJ Cymru submits that an in-date stockpile of this life-saving equipment ought to have been maintained, and that the failure of the Welsh Government to do so requires careful scrutiny.

17) Another area in which the Welsh stockpile was seriously deficient was long sleeved gowns, and of the target stock of 573,600, Wales had zero in stock - not a single surgical gown. Indeed, it is to be noted that when surveyed in February 2021, doctors in Wales identified the availability of FFP3 respirators and surgical gowns as key areas of concern [INQ000214235_0031].

18) Further, despite the focus in Exercise Cygnus on ensuring each organisation was aware of "how [the Welsh stockpile] would be distributed to them" [INQ000187149_0004], this plainly did not happen. Witnesses from Wales consistently acknowledged that there was a lack of communication and understanding of how, and to where, stock would be distributed during the pandemic.

Extent of the deficiencies: comparisons with the other UK nations

19) The Inquiry has heard evidence that the pandemic stockpiles were deficient in all four nations in the UK. However, this should not mask the extent of the failures in Wales. Again, the issue is most marked in respect of FFP3 masks.

20) By 12 March 2020, a DHSC email records that "Wales are in the most challenging position" of the 4 nations [INQ000551495_0002]. By that stage, Wales had already had to rely on 100,000 FFP3 masks from England, of which only 10,000 remained [INQ000551495_003]. Supplies were well below those available to the other UK nations per capita, as the table below demonstrates.

Table 1: FFP3 mask to population ratio

UK Nation	Number of in date FFP3 masks 12 March 2020	Population in mid-2020 (ONS)	Mask to population ratio
England	1,500,000	56,550,000	1:48
Scotland	113,000	5,466,000	1:38
Wales	10,000	3,170,000	1:317
Northern Ireland	99,000	1,896,000	1:19

Sources: INQ000551495 and ONS population statistics in mid-2020.

21) As shown above, Wales' stockpile of FFP3 masks was woefully inadequate and well short of supplies in other UK nations. To put that in context, despite having almost double the population of Northern Ireland, Wales had only 10% of their supply of FFP3 masks.

Addressing the deficiencies: Just-In-Time contracts and re-testing of FFP3 masks

22) It remains unclear if, when and how the Welsh Government addressed deficiencies. An emergency 'Just-In-Time' order had been placed by 18 March 2020 [INQ000505360], but as the Inquiry has heard in oral evidence, 'Just-In-Time' contracts did not deliver. The Audit Wales report of April 2021 reported that the 'Just-In-Time' contracts failed. Audit Wales stated that, *"due to a lack of supply in the global market, these 'just-in-time' contracts did not deliver as fully as expected, with none of the FFP3 respirators being received*" [INQ000214235_0013 at §1.3].

23) The CBFJ Cymru invites the Inquiry to approach the evidence that the Welsh Government ensured swift re-testing of out-of-date FFP3 masks with caution. Mr Brace said that, as far as he was aware, there was no problem with out-of-date stock – it had been re-tested (it was simply that it had not been given a label to confirm it had been re-tested, thereby giving rise to concerns among the trade unions that stock was out of date). His evidence suggested, in other words, there was no problem with out-of-date stock at all [Brace; 6/182/19-6/183/5 and 6/183/20-6/183/24]. Similarly, Jonathan Irvine, director of procurement at NWSSP, gave evidence that the FFP3 masks were re-tested and in circulation by 25 March 2020 [Irvine; 14/114/18]. However, Welsh Government records show that as of 18 March 2020, the FFP3 stock remained out of

date, with re-testing achievable within 4 to 16 weeks to re-test, depending on the age of the stock [INQ000504943].

24) Regardless of the exact time frames of re-testing, the CBFJ Cymru is concerned about a number of aspects of the re-resting. First, it seems clear the body in Wales responsible for re-testing, Surgical Material Testing Laboratory ("SMTL"), did not have the expertise or relevant equipment needed to conduct re-testing. This is acknowledged in its own report ("Test Report, 27 February 2020"[2]) which records that aspects of the testing had to be subcontracted.[3] Secondly, the face-fit testing SMTL undertook returned a high failure rate: it was a "fail" in half the cases, owing to face size, shape etc. - largely because they did not fit women (Test Report, 27 February 2020; Table 4 p.9; Discussion p.13 at §8.1). Given 70% of the health and social workforce are women, the figures are highly troubling. Plainly, if the masks do not fit, they offer no protection to the health care workers or patients they are designed to protect. Thirdly, the CBFJ Cymru notes the 3M Respirator timeline analysis report makes reference to the SMTL report and claims it "*demonstrates that the products are safe to use*" (INQ000269725 entry for 28 February 2020). The CBFJ Cyrmu questions how this can be the case given, as the report itself acknowledged, such a high proportion failed the fit test.

Reasons for deficiencies in Wales' stockpile

25) It must be stressed that the deficiencies cannot be attributed to a UK-wide PIPP strategy which underestimated the demand in the event of a pandemic: the Wales stockpile did not contain that which it was supposed to contain. And it was the responsibility of the Welsh Government, not Westminster, nor the NWSSP, to maintain adequate and in-date stock.

26) As to why stocks were out-of-date, Mr Irvine could not assist when he gave evidence at the Inquiry. He made clear that the Welsh Government were aware of the problems: there were regular stock reviews carried out with Welsh Government officials. "*I'm not trying to be evasive*", he said, "*that would have been a decision that Welsh Government would have had to have taken and it would have been a matter for them to have*

[2] This document is Appendix B referenced in INQ000269725_0001 entry 28.02.2020 re. Welsh colleagues

[3] The CBFJ Cymru observes that even today, SMTL's current UKAS certificate demonstrates it does not have the accreditation to test FFP3 masks; if it were the case it was also not accredited in 2020, the group questions why it was instructed to conduct the re-testing on behalf of NWSSP in the first place and notes the obvious risk to healthcare workers (and patients) arising from such a decision.

answered" [Irvine; 14/111/7-11]. The CBFJ Cymru observes that the Welsh Government have not answered that question. Notwithstanding witness statements totalling hundreds of pages, and notwithstanding thousands of exhibits, the answer to this very simple question remains elusive.

Conclusion

27) The CBFJ Cymru urges the Inquiry to view with caution the assertions which appear (verbatim) in several statements prepared by those working for the Welsh Government that the stockpile was "*crucial during the first four months of the Covid-19 response and gained time to enable the NHS Wales Shared Services Partnership to successfully secure ongoing PPE supplies*" [Slade; INQ000506956_0042 at §174; Gething INQ000536418_0024 at §104]. Talk of "success" is inappropriate. Supplies were not secured. Members of the group experienced firsthand the devastating effects of shortages of PPE and inadequate PPE. The Chair will have to make recommendations following this Inquiry. And yet, in the absence of any recognition and explanation of the failure of the Welsh Government to maintain adequate stockpiles, the opportunity for the Welsh Government to learn lessons for the future is necessarily limited.

PPE AND EQUIPMENT IN HOSPITALS

Introduction

28) After some introductory remarks, this section on PPE and equipment in hospitals covers:
    a) Wales "never ran out of PPE": a misleading claim
    b) Extent of shortages of PPE and equipment in hospitals
    c) Reasons for shortages/inadequacies in type of PPE in hospitals
        i) Distribution problems
    d) Conclusion

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

30) The Inquiry will be aware that many CBFJ Cymru members suffered bereavement following a hospital or care home acquired infection. The CBFJ Cymru believe that the lack of adequate PPE within Welsh hospitals and care homes was a major cause of the high levels of infection and deaths experienced. Such nosocomial transmission is

one of the principal symptoms of the failure to distribute PPE and equipment to hospitals.

Wales "never ran out of PPE": a misleading claim

31) The Inquiry has been told repeatedly by the Welsh Government and its politicians that, on a national level, PPE stocks in Wales never ran out [e.g. witness statement of Mark Drakeford INQ000528293_0007]. Alan Brace, Andrew Slade and Jonathan Irvine all repeated that Wales "never ran out" of PPE when they gave evidence to the Inquiry.

32) The claim that Wales "never ran out" of PPE has the potential to be a highly misleading claim. This is because those monitoring and distributing the stock – NWSSP - were also the ones managing requests for PPE, determining what proportion of any request would be supplied. Mr Irvine may not have liked the term "demand management" when asked in evidence whether Wales engaged in "demand management", but that is the very process he described:

> *"I wouldn't term it in that way [demand management]. Certainly in the initial two, three weeks, maybe four weeks…most of March…We were dealing with a finite amount of stock that was held in the PIPP stockpile, with no, certainly up to the third week of March, I would argue, no clear line of sight as to how that was going to be replenished or if it was going to be replenished. Bearing that in mind and hearing in mind what'd I'd just previously said about potential…almost panic to get product into the hospitals, we had to make sure that all PPE stockpile was available to all health boards and trusts across Wales. We couldn't have a position where one health board came in and took 60-70% of the stock leaving others without anything. So in this respect we had to make sure there were sufficient quantities for everybody. So we had to make a determination"* [Irvine; 14/130/20-14/131/17].

33) To put it another way: if Wales did not run out, it is not because demand was met, it was precisely because demand was not met, NWSSP allocating in order to ensure its stockpiles did not run out, rather than allocating to meet need.

34) In any event, even if Wales did not run out at a national level, the more relevant issue is why healthcare workers and patients in hospitals did not have the necessary PPE.

Extent of shortages of PPE and equipment in hospitals

35) Just over five years ago, Wales reported one of its first deaths from a hospital acquired covid infection. Douglas Miles was admitted to the Holywell Community Hospital in Denbigh for an operation. But he caught covid whilst in hospital and, tragically, on 29 March 2020, passed away. His daughter, Sylvia Parry, said "there was no PPE at the time and my father was just a sitting duck in the hospital". She observed undertakers attending in full hazmat suits, whilst healthcare workers, reliant on supplies from Local Health Boards, had nothing. It would prove to be one of the first of many deaths in Wales from nosocomial covid infection. And it is a story to which many in the group relate:

a) Ann-Marie Richards (from whom the Inquiry heard in the Module 5 impact video). Her husband went into hospital in December 2020 to be treated for sepsis. He caught covid in his ward and tragically never recovered. When Hywel Dda Health Board reviewed his case, they found that on Mr Richard's ward, 25 patients had tested positive for covid, and 25 staff members had tested positive for covid. The Board simply told Mrs Richards, opaquely, that "exposure to multiple hospital environments would have made Mr Richards more vulnerable to hospital acquired infections".

b) Sam Smith-Higgins, co-leader of the CBFJ Cymru group. She told the Inquiry in her oral evidence in Module 4 [2/115/21-117/22] about her fears for her 73-year-old father, who was admitted to hospital in early January 2021 for cancer related treatment and was immune suppressed and vulnerable. He was not permitted access to a high efficiency particulate arresting ("HEPA") filter (even though they are low cost and portable, and even though Ms Smith-Higgins offered to source one herself). Nor was he ever offered a mask. Tragically, just three weeks after being admitted to hospital, he died from a Covid-19 infection acquired in hospital.

c) Anna-Louise Marsh-Rees, co-leader of the CBFJ Cymru group. Her father went into hospital for a gall-bladder operation. On his non-covid ward, 21 patients had covid. Tragically, of those, 12 - including Anna-Louise's father - passed away from Covid-19.

36) There are many more such examples. The experience of many in Wave 1 was that they would attend hospital to find healthcare workers "with zero to minimal PPE". In Wave 2, members saw healthcare workers generally equipped with surgical masks, gloves and aprons, but no FFP3. By that stage, of course, the nature of aerosol

transmission of Covid-19 was known, and yet healthcare workers were under-protected. The result was that patients caught covid whilst in hospital.

37) It was well known in communities across Wales, particularly as the pandemic went on, that there was a high risk of nosocomial transmission upon admission to hospital. Families felt a grim inevitability that, if admitted to hospital during the pandemic, their loved one would contract covid. Their fears were well founded: data from Public Health Wales ("PHW") showed that, as of 24 February 2021, of the 1,002 patients in Welsh hospitals testing positive for covid, 529 of these (53%) were classified as "hospital onset" cases [INQ000227307_0002]. The situation has not improved: PHW data as of 09 February 2025 shows some 83% of inpatient Covid-19 cases in Wales were the result of hospital-acquired infection.

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

39) Examples of re-use of PPE tell a similar story of shortage. As Adam Morgan from Wales TUC observed in his witness statement in Module 2B [1NQ000400723_0024]:

> *86. The Welsh Government did not follow the UK guidance to reuse PPE. Nevertheless a GMB representative reported that staff in Welsh hospitals were being encouraged to share PPE that should have been single use, including versa-flow hoods that workers would breathe through for entire shifts. When staff complained, they were told that they had no choice. Staff were alarmed by the risk of infection created by reusing colleagues' hoods, and the suggestion was only dropped after significant resistance from Unite. I was told*

by CSP members that the advice regarding appropriate PPE appeared to be based on availability rather than the level of protection afforded [Exhibit AM/58 - INO000339547].

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

Poor ventilation in Welsh hospitals

41) PPE shortages were exacerbated by inadequate ventilation in Welsh hospitals. The CBFJ Cymru reminds the Inquiry of the evidence of Dr Shin in Module 3 that there was insufficient consideration given to ventilation beyond the opening of windows. Dr Shin in his oral evidence recommended common-sense alternatives to installing new ventilation, namely UV filtration system and HEPA filters [Shin; 08/172/3–08/174/4] which were low cost and portable. Baroness Morgan flippantly joked that a HEPA filter had been her most disappointing Christmas present [Morgan; 35/195/6-8]. On the contrary, for CBFJ Cymru, HEPA filters are a valuable piece of equipment which could have reduced nosocomial transmission rates and potentially saved lives. The Inquiry will also be aware of the evidence in Module 2B of the Chief Nursing Officer for Wales, Professor Jean White, who explained that the hospital estate in Wales was old, and would not have therefore been well ventilated [White; 6/114/20-25].

Reasons for shortages/inadequacies in type of PPE in hospitals

42) Whether as a result of "demand management" by NWSSP or not, even if Wales did not run out of PPE, that is of little comfort to those who experienced shortages at a local level. What good is a long-sleeved gown and FFP3 mask in a warehouse in Denbigh, when it is needed at the local hospital, where covid is spreading through the ward, among staff and patients alike? Or, as Professor Manners-Bell put it:

> "*not getting [goods or] PPE to the right place means a critical supply chain failure. You [might as well not] have bothered to have had those goods in the*

first place if you're not able to get them to where they're needed at the right time, to the right people." [Manners-Bell; 5/12/22].

43) Failure of planning and preparation resulted in a Welsh stockpile that was woefully lacking in Respiratory Protective Equipment such as FFP3, and faced with no means of procuring sufficient stock, this equipment was rationed to ICU settings and AGP procedures by means of the IPC guidance, leaving patients and staff outside of these settings more vulnerable to infection. The group considers this to be one of the main underlying reasons for the shortages – and is explained in further detail above (Pandemic Stockpile) and also below (IPC Guidance and FFP3 masks).

44) A further reason for shortages is distribution of PPE.

Distribution problems

45) Mr Slade (Welsh Government) suggested problems in supply and distribution related to a lack of information about (i) what was needed and where and (ii) what stocks were held at a local level. There was, apparently, no system of knowing how much stock hospitals had – they were starting from scratch. So, problems arose because there were inadequate flows of information and intelligence.

46) Mr Brace (Welsh Government) suggested confusion in distribution was caused by IPC guidance: "*the change in guidance…caused a lot of tension at the direct service end around what PPE was required and did we have the right mix of PPE*" [Brace; 6/202/19-24]. He suggested that guidance led to tensions in staff understanding what was required and therefore supplied: his claim was unsubstantiated, but in any event was a red herring, given (as the Inquiry has heard in previous modules) changes in IPC guidance did not substantially alter PPE e.g. mask wearing.

47) And like Mr Slade, Mr Brace suggested there was plenty of stock, but there were problems with information about that stock. He said: "*there weren't any hospitals without stock…but there clearly was coordination issues at the hospital end about what stock was held and where, and how to distribute it as quickly as possible across the various sites and hospitals and hospitals within the hospital*". [Brace; 6/189/1]. He described it as a "*disconnect*" between the Local Health Board's understanding of available stock, and NWSSP's understanding that they had "*pushed out enough stock to the NHS*" [Brace; 6/189/8-6/190/4]. He later seemed to suggest it was simply about

speed: it went to a distribution point [Brace; 6/204/5-14], but it was about how quickly it could get to the wards: "*every hospital has got a central receipt and distribution point that then distributes to wards. So there would have been stock in receipt and distribution points and I guess the challenge was how was that – how quickly…*" [Brace; 6/204/9-13].

48) And finally, Mr Brace suggested problems in distribution were because NWSSP operated a "push" system, rather than a demand system – which was how they normally operated with the local Health Boards [Brace; 6/205/4-8]. He did not elaborate further.

49) Such explanations raise more questions than answers. NWSSP had been supplying PPE to Health Boards and hospitals for the best part of a decade when the pandemic started (since 2011). Distribution paths and delivery points must have been well established. Why had not even the most basic stock management system been put in place? Why did NWSSP use a "push" system, when it had not done so previously? And if it is correct that there was plenty of stock floating around the NHS estate in Wales, why did the problem go unattended or unsolved, once it was realised (certainly by 30 April 2020, when the military logistics report was produced [INQ000470703] that this was a serious problem.

50) Whilst the Welsh Government felt, as Mr Brace said in evidence, "confident and assured" they had a grip on the situation in April/May 2020, this was evidently not the case. Healthcare workers and members of the group alike witnessed shortages throughout 2020 and into 2021:

    a) In April 2020, an RCN survey of nurses in Wales reported on the sufficiency of particular PPE items: only 52% had sufficient eye protection; 46% - Type IIR masks, 63% - FFP3 respirators, 57% long sleeved gowns.
    b) In February 2021, a BMA survey of doctors in Wales reported that just 37% had sufficient PPE for non-aerosol generating procedures, whilst 44% said that it was not adequate. As to PPE items that would help doctors feel safe, 88% identified FFP3 masks and 45% identified long-sleeved disposable gowns [INQ000214235 - Procuring and Supplying PPE for the covid-19 pandemic, Audit Wales 2021].

51) The reasons that essential PPE and equipment failed to reach the frontline are far from clear. The Inquiry heard from Welsh Government witnesses and NWSSP. They, by

inference, pointed the finger to failings at a more local level. That may be correct, incorrect or partially correct. The position is not known. Significantly, no evidence was called from those operating at a more local level, such as the Local Health Boards, who may have been able to provide the Inquiry with valuable insights into whether and why there were distribution and logistics problem at a Local Health Board or hospital level.

Conclusion

52) Notwithstanding the repeated claims that the PPE stocks distributed by the NWSSP never ran out, the reality was that they did; or at least stock did not reach those who needed it. Plainly healthcare workers are among those who needed it most.

53) Many of the group question why the Welsh Government was so slow to react to the issue. Many of them question why the staff and patients and residents in hospitals and care homes were unable to take the precautions necessary to curb the spread of the virus. They believe that the reason why Wales has the highest rate of nosocomial deaths must have been due to the lack of any PPE, or appropriate PPE, resulting in mass cluster outbreaks in wards and care homes across Wales.

54) Given that there was such limited exploration as to why those that needed PPE did not have it, the concern of the CBFJ Cymru is that there remains a significant gap in understanding this key aspect of the module. And, again, without an understanding of the problem, there can be no confidence or assurance that the Welsh Government have learned any lessons for the future.

PPE AND EQUIPMENT IN CARE HOMES

Introduction

55) After some introductory remarks, this section on PPE and equipment in care homes covers:

a) Wales "never ran out of PPE" in the social care sector: a misleading claim

b) Extent of shortages of PPE and equipment in care homes
c) Reasons for shortages/inadequacies in type of PPE in care homes
    i) Delays in recognising the PPE needs of care homes
    ii) Distribution problems
d) Other concerns about PPE and equipment in care homes
    i) Shortcomings in the level of protection offered in care homes
    ii) IPC guidance for care home workers on the use of PPE was inadequate

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

57) The supply of PPE to care homes is a particular concern for the members of the CBFJ Cymru, a large number of whom lost loved ones in care homes during the pandemic.

Wales "never ran out of PPE" in the social care sector: a misleading claim

58) Here, again, the narrative from the Welsh Government is that, like the healthcare system, the social care system never ran out of stock. For example, Mr Brace said that the only time he was aware of a care home running out of PPE was a false alarm:

> *"a call came through to the ministerial team that one of the care homes in one of the local authorities in Wales had run out of PPE, and there was none available. I contacted Mark Roscow in Shared Services who said that's very unusual because the joint equipment store has been replenished. He sent a van there and actually the joint equipment store was complete with stock, but there were clearly communication or distribution issues just between that care home, the local authority, and the joint equipment store"* [6/201/9-21].

59) The basis upon which this is said has not been explained or explored. To the extent that it relies on stock data from the Welsh Government/NWSSP that Wales never ran out of stock at a national level, such a claim is potentially misleading: demand management ensured that it never ran out, irrespective of demand and/or need (see above in respect of hospitals).

In any event, the claim is misleading. There is an overwhelming amount of evidence that shows that those in care homes did not have the PPE, and type of PPE, they

needed. And those who experienced first-hand the shortages, and the use of inappropriate PPE, will no doubt find it hard to understand why the PPE Supply and Distribution Cell for the Welsh Government, headed by Mr Brace, was apparently so misinformed. The failures to supply care homes with adequate and appropriate PPE and equipment are widely reported; they cannot be denied.

Extent of shortages of PPE and equipment in care homes

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

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

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

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

62) And furthermore, Dr Chris Llewelyn observed that even if NWSSP made available the quantity of stock (such that "demand appeared to be met") this was not necessarily the correct stock:

"47. The WLGA is also aware of circumstances where demand for PPE was met 'on paper' however in practice the supplies could not be utilised by care professionals. For example, throughout August and September 2020 the overall quantity of nitrile examination gloves available to the care sector was sufficient, but they were not available in sizes that could be used by care professionals…

48. This issue was not exclusive to gloves and issues were experienced with other PPE equipment. For example, aprons issued as 'one size fits all' did not provide significant coverage to some care workers and there were concerns that there was a risk of workwear being contaminated during personal care interventions. With regards to masks, some workers experienced a reaction to certain brand masks which potentially contained latex, while other brand masks did not mould around the nose appropriately resulting in staff constantly touching them to re-adjust. These products were eventually withdrawn from use, but at a point in time would have been considered as meeting PPE demand". [INQ000518355_0020-21 at §§47-48]

63) Statements from Ms Herklots and Dr Llewelyn are consistent with the experiences of the members of the group itself. Catherine Griffiths' tragic experience epitomises this. Her father contracted covid in his care home in Aberystwyth. She describes the last time she saw him:

"On 16th November 2020, I was invited to the home to say 'goodbye' to Dad. I wanted to go in and be by his side and to hold and comfort Dad; my brother urged me not to. The level of PPE in the home was abysmal; we could see the nurse wearing just an apron and a flimsy surgical mask. I was forced to say goodbye to my father whilst standing in the icy rain, outside his window." [INQ000474759_0020 at §69[4]]

Reasons for shortages/inadequacies in the type of PPE in care homes

64) The claim that Wales never ran out of PPE in the social care sector (evidently incorrect) is in any event an irrelevant one. To repeat the evidence of Professor Manners Bell: *not getting [goods or] PPE to the right place means a critical supply chain failure. You*

[4] Statement disclosed in Module 6

[might as well not] have bothered to have had those goods in the first place if you're not able to get them to where they're needed at the right time, to the right people.". [Manners-Bell; 5/12/22]. What good is a mask in a warehouse in Bridgend, when it is needed at the local care home, where covid is spreading through the home, among staff and patients alike? The more relevant question is why care homes experienced such shortages and what were the nature of the shortages. The CBFJ Cymru note the following reasons for shortages from the evidence available:

a) Delays in recognising the PPE needs of care homes
b) There were distribution problems

Delays in recognising the PPE needs of care homes

65) There was a delay in providing PPE to care homes. As Mr Slade told the Inquiry, the likely need to deliver PPE to social care settings was recognised as early as 18 February 2020 [INQ000470674]. Yet it was not until 19 March 2020 that the remit of the NWSSP was extended to procure and supply care homes. Those operating at a local authority level felt that the Welsh Government failed to recognise the needs of social care settings, as it prioritised supply of PPE for the NHS [INQ000518355_0009 at §19 and §21].

66) During the first few months of Covid, and notwithstanding the expanded role of the NWSSP on 19 March 2020, councils were seeking supplies of PPE from the NHS, but such supplies were dependent on a positive case being identified, and in any event the nature and timing of provision from NHS stock was unknown. Local authorities had to forecast demand, place their own orders and chase supply [INQ000518355_0010 at §§20-22]. By May 2020 only two thirds had their PPE needs meet by NWSSP. It was not until much later – September 2020 – that a Service Level Agreement between the NWSSP and the WLGA was reached [INQ000518355_0010 at §§29-30; 43], an agreement only formalised in a letter to social care providers on 12 October 2020. By that stage, of course, Wave 2 of the pandemic was already underway.

67) Mr Slade did not accept care homes had been overlooked whilst the NHS was prioritised. Nor did he accept that the Welsh Government could and should have acted more quickly to assist care homes. But the recognition by both himself and Mr Brace that, in a future pandemic, NWSSP should or would provide PPE immediately for the care sector tells you that the response to supply PPE to care homes was too slow.

68) The delay is epitomised by the reaction of the Welsh Government to the request from Ms Herklots for an Action Plan to address the problem of care homes in Wales. Ms Herklots met Julie Morgan, Deputy Minister for Health and Social Services, on 9 April 2020, to raise concerns about the situation for staff and residents in care homes, and the anxieties felt by their loved ones. By that stage, as Ms Herklots noted, Ms Morgan had announced that there had been confirmed or suspected cases in nearly a third of Wales' care homes. Further to the meeting, on 14 April 2020, Ms Herklots wrote to the Ms Morgan and invited her to make an Action Plan [INQ000184935]. She explained the rationale for the Plan when giving evidence to the Inquiry in Module 2B:

> *"I struggling to see how the work to help older people living in care homes and those working in them, how that was being led and co-ordinated… and if I was struggling to see it, it was going to be even more difficult for people in care homes and families and friends to actually see what was happening....there needed to be an urgency and focus, that I couldn't see at the time*." [Herklots; 2/130/3].

69) Ms Herklots asked Ms Morgan to lead and set out an action plan to drive faster progress, faster action to protect older people. By reply on 21 April 2020 [INQ000184940] Ms Morgan said she was:

> "*…not convinced that an additional plan of action over and above those arrangements…will add value here but we will certainly report on progress via the Social care Sub-group."*

70) Ms Herklots was, unsurprisingly, angered that Ms Morgan was suggesting that working on an action plan "*would add no value, at a time when people were dying in care homes, where families were distraught."* [Herklots; 2/131/2]. It took a report published on 21 June 2020, *"Care Home Voices: A snapshot of life in care homes in Wales during Covid-19"* [INQ000181725] to jolt the Welsh Government into action. An Action Plan was eventually published on 30 July 2020, over three and a half months after the Welsh Government had been asked to prepare a plan. The CBFJ Cymru is concerned that valuable time was lost to protect this most vulnerable of populations in Wales.

Distribution problems

71) Another reason for lack of PPE and appropriate PPE in care homes appears to have arisen from distribution problems. We know that NWSSP supplied stock from its national stores to Local Authority Joint Equipment Stores, for onward distribution to the care sector by local authorities. We also know that this process did not work as it should have.

72) Mr Irvine said there was "more than enough PPE in the joint equipment stores…but the Joint Equipment Stores or local authorities more generally weren't necessarily aware of what was actually there" [Irvine; 14/154/16].

73) Mr Irvine's suggestion is hard to understand: it implies local authorities and care homes, desperately in need of PPE, could have had more than they needed, if only they'd checked their local joint equipment store. If that is right, then the obvious question arises: why was the matter not be resolved easily, by simple and better communication between NWSSP, local authorities, and the end user?

74) Mr Irvine's suggestion is also hard to understand given Stock Watch, the inventory management system designed to enable NWSSP to understand what was needed and where, was unfit for purpose (and was recognised by Mr Irvine as such). The system relied on email updates from local authorities, or, from November 2020, direct input from local authorities themselves. Whichever the method, NWSSP were not able to "understand that we were fulfilling their full requirements" [Irvine; 14/153/22] and there were "gaps in how much stock [those] areas actually required" [Irvine; 14/135/25]. If the Inquiry were to accept that the joint equipment stores were full to overflowing, that would have been by luck, rather than by design. It is a question of "if": the Inquiry has not heard from the local authorities and care homes providers; it might be that they would provide some useful information on how or why the system failed from their perspective. They may even have a narrative to counter the implicit suggestion that failures lay with them, at a local level.

75) The Welsh Government had little to offer by way of their own insights into problems in care homes. Mr Brace said he "*would not want to comment about every instance of where that was felt in social care*" [Brace; 6/203/18]. Indeed, he did not comment on any instance – beyond saying there was one false alarm. Nor could Mr Irvine help – he said "*the more important issue*" was to understand the responsibilities of NWSSP and "*where they started and where they ended*" [Irvine; 14/155/17-20] – i.e. it was not the responsibility of NWSSP. Such siloed thinking perhaps reveals more than Mr Irvine

intended. It certainly assists the CBFJ Cymru in understanding why problems, once identified, would not be resolved. Unlike Mr Irvine, for the members of CBFJ Cymru, the most important thing was not where NWSSP's role started and ended. It was why healthcare workers and residents in care homes were so overlooked and poorly serviced when it came to PPE and essential healthcare equipment, and why their loved ones died because a lack of proper protection.

76) Finally, there is a shortcoming underpinning these distribution concerns, which suggests distribution to care homes in Wales was always going to be problematic. As the former First Minister, Mr Drakeford, admitted in oral evidence during Module 2B [Drakeford; 11/211/15], there was no single register of the location of every care home in Wales. Having regard to this position, the CBFJ Cymru suggests that it will be important for the Inquiry to understand how the Welsh Government was able to ensure the supply of necessary PPE to care homes, when the extent of their existence and operation was not known.

Other concerns about PPE and equipment in care homes

77) The CBFJ Cymru note the following additional concerns in relation to PPE and equipment in care homes in Wales:

a) Shortcomings in the level of protection offered in care homes
b) IPC guidance for care home workers on the use of PPE was inadequate

Shortcomings in the level of protection offered in care homes

78) There were shortcomings in the level of PPE protection in care homes. The NWSSP packs prepared and distributed to local authorities for onward distribution to care homes contained a fluid resistant surgical mask, apron, gloves and eye protection [INQ000470675]. These were the items that were subject to the SLA formalised in September 2020 and about which care homes were formally notified on 12 October 2020. These items continued to comprise the stock made available to care homes via their local authorities throughout the pandemic (as shown by data from Stock Watch, the electronic stock management system) [INQ000436116]. Yet, as set out below, FFP3 masks - absent in the packs - were essential in preventing the spread of aerosol transmission.

IPC guidance for care home workers on the use of PPE was inadequate

79) The IPC guidance for care home workers on the use of PPE was inadequate. PPE guidance for care homes was based on UK/national level guidance. It therefore suffered from the same failings as nationally agreed IPC guidance (further details in the section below).

80) The effect of the failure to recognise the asymptomatic nature of the virus, and its airborne transmission, was particularly marked in care homes. The Minister for Health and Social Care, Vaughan Gething, announced on 16 March 2020 that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. A letter to social care providers on 18 March 2020 following Mr Gething's announcement confirmed (i) PPE was for those directly caring for confirmed or suspected cases, and (ii) that higher level of PPE was "unlikely to be needed" in a social care setting – such equipment only being needed by those undertaking AGPs [INQ000470681].

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

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

82) The lack of clarity had a knock-on effect on supply: the guidance left room for interpretation and as such affected usage, and in turn hampered the ability to accurately predict demand for PPE in the care sector [Dr Chris Llewelyn, INQ000518355_017 §36].

83) For completion, we note that the most recent PHW IPC guidance for Acute Respiratory Infections ("ARIs") in Wales (2024-2025)[5] recommends that social care staff use "*FRSM (type IIR) when working in respiratory care pathways and when clinically caring*

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

for suspected/confirmed COVID-19 and Flu patients" (p.8/17) and only recommends FFP3 masks "*if an unacceptable risk of transmission remains following the hierarchy of controls*" (p.15/17). It is not known how those in care homes – a "high risk setting" because they cannot mitigate risk with a hierarchy of controls (p.6/17) - are expected to conclude there is "unacceptable risk following the hierarchy of control", such that FFP3s are required. It seems therefore that current guidance for care homes does little to correct deficiencies in earlier guidance.

VENTILATORS, OXYGEN AND CPAPS

84) The concerns of CBFJ Cymru in this module have not been confined to PPE but extend to key equipment such as ventilators and CPAPs.

85) The Inquiry heard much evidence as to the procurement activities for ventilators by the UK government. Of course, it is recognised that procurement of these significant pieces of equipment took place on a UK-wide basis. Whilst it is clear therefore that Wales benefited from such UK-wide procurement, a more detailed picture of whether Wales had sufficient ventilators (and how that was measured) is less clear. Certainly, its members experienced shortcoming and failures in access to ventilators and other key equipment, as the examples below show:

    a) Marita Edwards was admitted to hospital in February 2020 for a routine operation. She was otherwise fit and healthy. But she caught covid whilst in hospital and tragically she passed away. Her son, Stuart Loud, questions why she was not put on a ventilator, and whether this decision was a result of a lack of resources, which meant staff had to hedge their bets on whether younger people might be infected and would need that equipment.
    b) Paul Jones (who has provided a witness statement to the Inquiry) and his wife Karen lost their 25-year-old daughter, Lauren, in December 2020. Staff delayed getting her onto a ventilator until her oxygen saturation level was at just 10%, almost 24 hours after being notified that she would need to go on a ventilator. He wonders why a ventilator was not made available sooner.

86) The only witness to be called to give evidence on key equipment such as ventilators and CPAPs in Wales was Richard Davis, the lead government official with the Critical Equipment Requirement Engineering Team (CERET). He gave evidence to the Inquiry for some 30 minutes. He could not assist with issues of access to ventilators and CPAPs, save to say that CERET was directed away from involvement in

making/procuring ventilators and CPAPs – they were simply told what to do by NWSSP. He did say, adopting a now familiar line, that Wales "*never ran out of vital, critical equipment*" [Davis; 14/169/22]. The CBFJ Cymru invites the Inquiry to treat such claims with caution. There has been no scrutiny of such claims, and they sit at odds with the experience of the group's members.

INFECTION PREVENTION AND CONTROL ("IPC") GUIDANCE ON FFP3 MASKS

Introduction

87) After some introductory remarks, this section on IPC Guidance and FFP3 masks, this section sets out:
   a) Evidence that there is serious doubt that the IPC guidance was correct
   b) Evidence that that IPC guidance was driven by resource/constraints in supply
   c) Conclusion

88) The Inquiry will consider the operation and effectiveness of guidance in relation to key medical equipment and supplies [**"Outline of Scope" §3; LoI §§4-10: "Structures, systems and processes"**]. Although the primary focus of the Inquiry here may be guidance in respect of procurement, the CBFJ Cymru nevertheless is concerned to highlight the significant role played by IPC guidance in respect of PPE procurement.

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

90) The nature of the IPC guidance in so far as relevant to PPE procurement is summarised in the witness statement of Jonathan Marron [INQ000528391_0063 to _0068]. In short, the IPC guidance was that from 13 March 2020, FFP3 masks were recommended only for treatment in ICU, or for Aerosol Generating Procedures ("AGPs"). This guidance was said to be "*based on the reasonable assumption that the transmission characteristics of Covid-19 were similar to those of the 2003 SARS-CoV outbreak, mainly transmitted through respiratory droplets generating by coughing and sneezing, and through contact with contaminated surfaces*" [w/s of Jonathan Marron INQ000528391_0066 §245; IPC guidance at INQ000325350]. This "reasonable

assumption" requires scrutiny, given the large body of evidence pointing to transmission via aerosol (in addition to droplets).

91) Against this background, CBFJ Cymru makes two main submissions:
    a) There is serious doubt that the IPC guidance was correct
    b) There are serious concerns that IPC guidance was driven by resource/constraints in supply

Evidence that there is serious doubt that the IPC guidance was correct

92) First, there must be serious doubt as to whether the IPC guidance was correct to limit the use of FFP3s to ICU/AGP scenarios. This is not a question of having the benefit of hindsight. This is a question of failing to fully acknowledge the risk at the time the IPC guidance was issued that Covid was spread via aerosol transmission.

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

94) In this Module, the Inquiry heard from Rosemary Gallagher, Professional IPC Lead at the RCN. She confirmed that, in her view, aerosol transmission was overlooked, with the result that healthcare workers were placed at unacceptable risk in the workplace [Gallagher; 10/57/1]. IPC guidance prevailed which meant that healthcare workers were not given the Respiratory Protective Equipment necessary to prevent infection due to airborne transmission. The RCN advocated and campaigned for this at the time – this was not a question of hindsight.

95) Dr Eleri Davies prepared the corporate witness statement on behalf of PHW for the Inquiry for Module 5 [INQ000557344]. At §93, she states:

> *"Public Health Wales did not advise the Welsh Government that COVID-19 was only communicable following AGPs. We were aware that modes of transmission included droplet/aerosol and contact. Our communications with the Welsh Government were regarding the UK COVID-19 IPC Cell guidance and ensuring that the Welsh Government were familiar with any updates to that guidance."* [INQ000557344_0024]

96) However, during the pandemic, it seems PHW did in fact advise it was only communicable following AGPs, and did advise the Welsh Government that the virus was not transmitted by aerosol transmission. In an email dated 24 March 2020 to the Deputy Chief Medical Officer, Professor Chris Jones, Dr Davis reported:

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

97) This continued to be the case up until December 2021: in an email of that date to Welsh government colleagues, Dr Davis reported the view that "*the consensus view of the cell was that the IPC guidance as it stands was currently fit for purpose. There was no evidence that the mode of transmission of the virus had changed*" [INQ000252535_0002]. The group is concerned to understand whether PHW did, or not did, advise the Welsh Government on route of transmission, and why there is confusion over this position. The group understands that the Inquiry had limited time and resources available, but nevertheless considers it was a missed opportunity to explore this important issue – in so far as it related to PPE - with a witness from PHW.

Evidence that IPC guidance was driven by resource/constraints in supply

98) Secondly, there are serious concerns as to why IPC guidance sought to limit the use of FFP3s, in particular, the extent to which IPC guidance was driven by supply/resource

constraints, rather than the health and safety of healthcare workers and patients. It is well known that FFP3s cost much more per unit than fluid resistant facial masks (Type IIR masks): in Wales, the average unit price for FFP3 ranged between 10 to 110 times the average unit price of Type IIR masks over the period November 2019 to October 2020 (calculations based on data from NWSSP summarised in the report of John Manners-Bell [INQ000474864 at §329; Table 3]). Plainly, the issues with supply and resourcing impacted the IPC guidance:

a) Professor Jonathan Van Tam acknowledged in an email to the HSE on 23 January 2020 regarding appropriate levels of PPE that, whilst the maximum level Respiratory Protective Equipment was required: "*this was neither affordable nor practical for pandemic stockpiling*" [INQ000151353]. And on 20 March 2020 Professor Van Tam called for, "*a proportional plan for sensible prioritised use of what PPE we have and can get. In other words, given the science, given the reality of stocks, how can this be prioritised in the most sensible, risk-stratified way"* [INQ000381179].

b) Professor Catherine Noakes explained the reluctance to properly acknowledge airborne transmission, despite a growing evidence base, as (in part) a result of "*the significant resource and operational implications it would have for hospital infection control measures…"* [INQ000236261].

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

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

99) Such concerns were felt on the ground, at local authority level in Wales. Dr Chris Llewelyn, Chief Executive of the WLGA observed in his witness statement that:

"*local authorities were uncertain what to purchase and at what scale — it appeared that guidance was driven by what was available on the market rather than by products which were fit for purpose or achieved the conditions to limit the spread and impact of Covid-19*" [INQ000518355_0015 at §33].

100) A briefing note from Chris Jones, DCMO for Wales, dated 13 January 2021 confirmed that:

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

101) Thus, the CBFJ Cymru remain concerned that, as far as IPC guidance is concerned, the emerging picture is one of supply-led guidance, rather than guidance-led supply. Given guidance determined the procurement strategy, the result is that many healthcare workers in Wales were given a level of PPE insufficient to protect them, and their patients, from the virus. And this was so notwithstanding the growing body of evidence that the virus was spread by aerosol transmission from the early stages of the pandemic.

102) The real impact of IPC guidance on PPE is best understood with examples from people's day to day experiences during the pandemic. Two such examples of appear below:

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

b) A locally employed doctor told the BMA "*I was redeployed to ICU [Intensive Care Unit] part way through from AMU [Acute Medicine Unit]. The difference in protection was stark. In ICU we had full PPE for anyone suspected and were told by consultants to take our own PPE to any ward patients to protect*

ourselves […] On the AMU side, even though there is an undifferentiated take, self bought masks were not permitted (as they would frighten patients!) until a while after the CDC [Centres for Disease Control and Prevention] and WHO [World Health Organisation] recommendations were made. It was clear that ICU was prioritised and wards were having other 'guidance' to protect PPE levels. This is not equity, and judging by the level of staff COVID sickness in wards compared to ICU, and patient breakouts, there are indicators that staff and patients came to harm during this time due to these differences" (witness statement of Professor Philip Banfield on behalf of the British Medical Association [INQ000562457_0018] at §58).

Conclusion

103) Whilst the CBFJ Cymru is aware the IPC guidance was considered in a previous module, the group urges the Inquiry to address the issue afresh in the context of the cross-cutting issue of adequacy of PPE supply. Professor Catherine Noakes, from whom the Inquiry heard in 2023 explained the reluctance to properly acknowledge airborne transmission was in part because of "*the significant resource and operational implications*" of doing so. Consistent with that, the Audit Wales report put the cost of an FFP3 mask at 110 times the cost of a fluid resistant mask during the pandemic (October 2020). If supply shaped the IPC guidance, as many in the group fear, then no amount of analysis about PPE supply chains and distribution channels would assist in a future pandemic. What matters is that the appropriate PPE – offering the appropriate level of protection – is supplied.

104) It is a matter of very great concern to CBFJ Cymru that the IPC guidance should have been used as a means of rationing the procurement and provision of FFP3 respirators. While it is recognised that, due to inadequate preparation and planning, there were insufficient quantities of FFP3 stocks in the early months of the pandemic, with no immediate means of procuring adequate stocks, this does not excuse the failure of the IPC guidance to recommend that FFP3 (or at least some other form of RPE) was required to be used when treating patients with (or suspected to have) Covid-19. This inappropriate use of IPC guidance had the following consequences:

a) It failed to inform healthcare professionals of the risks they were exposed to in the workplace, by inaccurately advising that surgical masks (that do not protect against airborne infection and are not even classed as PPE) were appropriate protection against a deadly airborne virus.

b) It undoubtedly contributed to the high levels of nosocomial infections in hospitals and care homes, including to patients and healthcare professionals.
c) It artificially supressed the level of use of FFP3 masks and produced false levels of demand against which procurement was based (inaccurately).
d) Once world-wide demand for PPE eased in the summer of 2020, which provided an opportunity to procure enough FFP3 masks in preparation for the inevitable second wave (which proved to be more deadly than the first), this opportunity was squandered because only sufficient quantities of FFP3 masks for use in IPC settings and AGP procedures were purchased (in accordance with the flawed advice in the IPC guidance) rather than the quantities needed to protect healthcare workers and patients in more general settings.

LESSONS LEARNED

Introduction

105) After some introductory remarks, this section on lessons learned considers lessons learned from:
a) The Rt Hon. Mark Drakeford
b) Mr Vaughan Gething
c) Witness who gave oral evidence: Mr Brace, Mr Slade, Mr Irvine Mr Davis.

106) The Inquiry will make recommendations regarding the procurement and distribution to end-users across the four nations of the United Kingdom of key healthcare related equipment and supplies, including PPE, ventilators and oxygen (Final List of Issues; Outline of Scope).

107) The CBFJ Cymru urges the Inquiry to approach the recommendations and/or lessons learned offered by witnesses from the Welsh Government or its "arms-length" bodies with caution. The group observes that the tenor of lessons learned regrettably appears to be one of self-congratulation. Far from offering constructive criticism of Wales' performance in the area of procurement and distribution of PPE and key equipment, which would benefit future generations in the event of a future pandemic, their emphasis has been on Wales' success in procurement of PPE and equipment.

108) Of course, the CBFJ Cymru does not seek to undermine the hard work of many during the pandemic. Nor does it seek to minimise success where it is evidenced (that,

too, would do a disservice to future generations in the event of another pandemic). However, the group observed (what appeared to be) a reluctance to admit problems in Wales and a readiness to attribute the cause of problems to others (typically the UK Government) or to systems and structures beyond their control (poor levels of UK manufacturing, failures in the global supply chain).

109) This is not a concern levelled at one or two witness statements or witnesses. This is a concern levelled at the vast majority of those who have provided evidence, whether written or oral, on this topic for Wales. It is for this reason that the group seeks to emphasise this point to the Inquiry. The official position (for that is what it appears to be) that Wales, after overcoming some initial difficulties, got things right and managed things much better than other parts of the UK, is so widespread that it represents an entrenched culture of belief. This culture is epitomised by leadership of the Welsh Government during the pandemic: the Rt Hon Mark Drakeford and Mr Vaughan Gething, whose "lessons learned" are considered below.

Lessons Learned: the Rt Hon Mark Drakeford

110) Mark Drakeford has provided a witness statement in Module 5 [INQ000528293] at the conclusion of which he sets out his reflections and lessons learned [INQ000528293_0019 to 0021; §§80-91]. The Inquiry will find no assistance there in understanding why those in Wales did not have appropriate or adequate supplies of PPE and equipment and how such problems could be avoided in the future. It is devoid of critical reflection on Wales. Instead, the reflections comprise statements highlighting Wales successes and/or the UK Government's failures. We set out a few salient examples below:

a) In relation to procurement processes, Mr Drakeford reflected "the procurement processes in Wales, were robust, effective and transparent" [INQ000528293_0019 at §80]. This is inaccurate. Not a single PPE contract scrutinised by Audit Wales was published in accordance with required procurement practice [INQxxx].

b) In relation to procurement, Mr Drakeford reflected "the success of the procurement of PPE in Wales was facilitated by the crucial early decision for a Barnett allocation of funding to Wales, rather than funding from a centralised UK pot". Talk of "the success of the procurement of PPE" is vague and inaccurate: what is the "success" to which he refers, when so many, for much

of the pandemic, did not have appropriate and sufficient PPE and healthcare equipment?

c) In relation to the amount of UK funding, Mr Drakeford said "I do not believe there were any issues with regards to the quantity of funding made available for the procurement of PPE and other key healthcare equipment in Wales". The UK Government allocated Wales £1.022 billion for PPE procurement. The Welsh Government managed to spend only £385 million (Slade [14/3/25; 14/74/15]). The question for many is why the Welsh Government spent only one third of what was available on PPE, when so many went without? And where did the rest of the budget allocated to PPE go?

d) In relation to distribution, Mr Drakeford cited the "valuable assistance of the military to review distribution arrangements." [INQ000528293_0019 at §81]. Their review may indeed have been valuable. But it was a one-week review in April 2020, which highlighted that Wales had no handle on stock levels. Distribution remained a problem throughout 2020 and into 2021. Mr Drakeford offers no reflection on why this occurred or how it could be prevented in future.

e) In relation to supply chain issues, Mr Drakeford said there was a need to invest in domestic supply chains and there should be an "articulated industrial strategy from the UK Government". Few would disagree that serious consideration must be given to the resilience of domestic supply chains. But here, in typical fashion, Mr Drakeford's lesson is not for Wales, but for those "particularly within HM Treasury" and the UK Government. The lack of "overall direction or a playbook" for Welsh manufacturers during the pandemic was not the fault of the Welsh government, but Westminster.

f) In relation to integrity of supply processes, Mr Drakeford raised (unspecified) concerns about the "integrity of processes run by the UK government in securing domestic supplies" only to praise the standards of integrity in Wales. Such reflections are vague and unsubstantiated. Whatever the truth of the standards that were applied in Wales, they did not translate to the adequate and appropriate supply of PPE and equipment to those who needed it most.

Lessons Learned: Mr Vaughan Gething

111) Mr Gething has made a statement for this module in which he sets out some lessons learned [INQ000536418]. As with Mr Drakeford, the Inquiry will find no assistance there in understanding why those in Wales did not have appropriate or adequate supplies of PPE and equipment and how such problems could be avoided

in the future. For, like Mr Drakeford, Mr Gething's lessons learned are devoid of critical reflection on Wales.

112) Remarkably, for someone who was the Minister of Health and Social Services, his collection of 'lessons learned' totalled just 300 words, most of which reveal an unwillingness or inability to engage with issues of substance. His "key reflections and lessons" include:

a) "How quickly stores of supplies, in particular PPE, can be exhausted during a pandemic, or similar event of this magnitude…";
b) "The need for broad political and public support if we are to seriously invest in improving the resilience of domestic supply chains…";
c) "The importance of mutual aid between the four nations…"
d) "We should expect a future pandemic to distress national and local supply chains as happened here…".

113) Beyond the statements of the obvious set out above, Mr Gething promotes the Welsh success story seen in Mr Drakeford's lessons learned. Further reflections noted: "The importance of a central purchasing and procurement system which focused on both quality and value for money and, crucially, did so in a fair and transparent way, without preferential treatment." Undoubtedly, a reference to the NWSSP, but a reference lacking any substance. This utopic vision of the Welsh PPE procurement system is betrayed by the facts:

a) the 'call to arms' to Welsh manufacturers to assist with PPE was late: it came on 20 April 2020, well after the shortages on the frontline were being reported [see e.g. concerns raised with the Welsh Government of 22 March 2020 – INQ000395479_0005];
b) PPE was substandard [Slade; 14/70/7]
c) Procurement lacked transparency [Audit Wales report 2021; INQ000214235]
d) And, most importantly, the system did not deliver. Those who needed PPE and equipment did not have it, particularly in the care sector.

Lessons Learned: other witnesses from Wales

114) As to lessons learned from those who gave evidence, the tenor is the same.

115) Mr Brace was asked about his lessons learned. He referred to the Audit Wales report: "*I think the Wales Audit Office report I'd fully agree with their insight and their*

recommendations for the future, so I won't repeat those" [Brace; 6/194/2]. In fact, the only criticism in that report was the lack of transparency in procurement contracts, so that lesson learned does not assist very much. The Audit Wales report was an overwhelmingly positive assessment. Mr Brace also felt better planning was needed, but did not elaborate on this further, save to say:

> *"I've always believed that plans are great but it's people that makes plans work, and we were really fortunate in Wales to have some very experienced procurement professionals sitting within an organisation that had central responsibility for buying, storing, distributing, and fairly sort of joined-up established relationships, and I think they were critical particularly in that phase of the pandemic*" [Brace; 6/194/14].

116) Mr Brace praised "small governance" - which translated to an ability to get ministerial approval quickly and put in place actions really quickly [Brace; 6/194/15-6/195/17]. But small governance did not translate to provision of adequate PPE and equipment to hospitals and care homes, and to that extent small governance did not assist.

117) Mr Slade said "there are definitely lessons that we can learn at a local level" [Slade; 14/86/14] but did not elaborate. Unlike the chief executive of the WLGA, he had no concerns about the Welsh Government's appetite to work collectively and inclusively with those at a local level.

118) Mr Irvine spoke to the need for resilience in the supply chain: a lesson with which few would disagree. He could not help with lessons to be learned on distribution – that was not the concern of NWSSP. As he put it "the more important issue here is to understand what the responsibilities of my organisation are and where they started and where they ended" [Irvine; 14/155/13-14/156/8].

119) And finally, Mr Davis spoke of his lessons learned: "*Governments need arms-length bodies and vice versa to ensure truth is brought to power based on sound information and intelligence*." [Davis; 14/181/10]. As to what that meant in practice – what truth was brought to Welsh ministers during the pandemic by CERET - he said that was "*out of the scope of my role as CERET*." [Davis; 14/181/17]. Regrettably, the group and the Inquiry are none the wiser.

120) Mr Davis reflected that CERET was a success since, "*Wales never ran out of equipment*" [Davis; 14/169/23] but this claim was not scrutinised and the lived experience of many members of the group would cause them to doubt its accuracy.

121) In summary, the group wishes to record its disappointment that the lessons learned from Welsh leadership and those in positions of responsibility appear to demonstrate little critical analysis about what went wrong in Wales. Those that did give evidence seemed more determined to defend the decisions they took than explore ways in which things could have been done better and thus to learn lessons for the future.

CONCLUSION

122) Just four witnesses gave evidence from Wales. Much of their evidence was dedicated to the technical and procedural aspects of procurement. But for the members of the CBFJ Cymru, the concern has always been to understand why those that needed PPE and equipment such as ventilators and CPAPs did not have it. In opening, the group asked why there were such shortages of PPE, why access to ventilators and equipment was inadequate, why the risk of nosocomial infection was so high in Wales, why care homes were overlooked, whether shortage in supply of FFP3 masks influenced IPC guidance, such that healthcare workers were inadequately protected. These questions, regrettably, remain unanswered. Gaps remain. And if gaps remain, and questions remain unanswered, there is of course a real concern that the Welsh Government have not learned lessons for the future.

Covid-19 Bereaved Families for Justice Cymru
6 May 2025