

COVID 19 INQUIRY
MODULE 7: TEST, TRACE AND ISOLATE

WRITTEN CLOSING STATEMENT
OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU (CBFJ CYMRU)

Introduction

1. This closing statement is focussed on matters affecting Wales and the implementation of the Test, Trace, Protect (Wales) programme (**TTP Wales**). There were significant differences in the Test, Trace and Protect policies employed in Wales, with numerous and substantial variances in approach, resources and deployment across the four UK countries throughout the relevant period (January 2020 until February 2022).
2. The CBFJ Cymru's shared lived experience of TTP Wales was one of a chaotic system where policies were ineffective, messaging was confusing, and implementation was inconsistent, late, contradictory and at times incoherent. Decisions in Wales were often different or taken later than in the other UK countries.
3. As the Inquiry is aware, the issue of nosocomial infections and deaths is a major concern of the CBFJ Cymru, many of whose loved ones died from infection acquired in a hospital or care home setting in Wales. The delayed and chaotic nature of the Welsh Government's implementation of TTP Wales contributed significantly to these tragic circumstances.
4. The submissions of the CBFJ Cymru are set out in accordance with the topics identified in the Inquiry's List of Issues (**LoI**):
 - Decision making
 - Infrastructure and capacity
 - Key policies

List of Issues 1: Decision-making, including the engagement between UK Government and the devolved administrations in relation to TTI systems

5. At a ministerial level, the Welsh Government frequently suggested they were given insufficient warning as to UK Government policy decisions. Mr Gething told the Inquiry, "*we were finding out things as they were being announced...on the hop*" [6/126/8-15]; Mr Drakeford commented that "*inevitably there were frustrations*" [6/185/3]. The CBFJ

Cymru is concerned to ensure that such complaints are approached with caution, given the Welsh Government's desire for political point-scoring apparent in this and other Modules, and the evidence of good cooperation and collaboration between the Chief Medical Officers and Chief Scientific Advisors (referred to by the CMO for Wales, Sir Frank Atherton, as "excellent cooperation and information sharing" [INQ000575984_0060]).

6. That said, there is at least once instance where the lack of engagement between UK Government and the Welsh Government raises legitimate questions: the setting up of Deloitte's mass testing site in Cardiff City Football Stadium.
7. PHW said this of the mass testing centre [INQ000587250_0075-76]:

335. ...A call took place [with Deloitte] on 1 April 2020, during which we were advised that Deloitte had set up a drive through mass sampling facility at Cardiff City Stadium and it would be ready to accept keyworkers for testing from 2 April 2020.

336. This was the first time that Public Health Wales was made aware that the mass sampling centre had been established. The Welsh Government was also not aware of its establishment until this time.

337. Following internal discussions, we spoke with Deloitte again on 2 April 2020 and asked them to "step down" the facility until Public Health Wales had had further conversations with the Welsh Government.

8. Jo-Anne Daniels, Director of TTP Wales from April 2020 onwards, confirmed in her evidence to the Inquiry that the Welsh Government was indeed apparently unaware of the mass testing centre [6/82/6-9].
9. Dominic Cook was a partner in the Major Programmes Team at Deloitte. He explained that Deloitte's role was to identify and build regional testing sites (RTS), such as the one in Cardiff. It was not Deloitte's role to seek approval from or liaise with the Welsh Government; Deloitte understood that the DHSC was responsible for such matters. Deloitte did, however, liaise directly with Cardiff City Council, and indeed had signed a lease with them in order to set up the RTS in Cardiff [5/155/24-156/5].
10. It is almost inconceivable that the Welsh Government and PHW - the lead agency responsible for public health in Wales - were unaware of the setting up of the largest mass testing site in Wales. If that was indeed the case, then it points to serious

communication failures between the UK Government and the Welsh Government. More relevantly for Wales, it points to a serious communication failure within government structures within Wales: how could it have come to pass that the Welsh Government and PHW were so adrift from the decision making of Cardiff City Council on such a key public health development during the pandemic? The communication failures take on a particular significance given the Welsh Government has repeatedly sought to impress upon the Inquiry in its 'lessons learned' the virtues of small governance, and the good levels of cooperation across the different levels of government. The debacle surrounding Cardiff RTS exposes the lack of substance of such claims.

11. Whatever the cause of the failure, it was, of course, the people of Wales who suffered the consequences. The site's opening was delayed by a week at a critical time in Wave 1 of the pandemic (April 2020), whilst PHW resolved issues relating to sampling methodologies and access to testing results (which, due to a lack of integrated systems, could not be seen on patient's records) [INQ000587250_0076, §339]. These are delays which could and should have been avoided, had basic communication channels existed between Cardiff City Council and PHW/Welsh Government.

List of Issues 2: Infrastructure and capacity

12. The Inquiry will consider what systems were in place to rapidly scale up, including in relation to test development, diagnostics, and national and local tracing.
13. The CBFJ Cymru is concerned that there was a limited ability to trace in Wales, let alone an ability to scale up testing and tracing systems in Wales. Despite numerous pandemic preparedness exercises in the last two decades, the Welsh Government did nothing to build capacity in testing and tracing systems. The CBFJ Cymru set them out here as they provide important context for the failures to scale up effectively.

2003: Exercise Shipshape [Module 1 - INQ000235217]

14. Exercise Shipshape was an exercise carried out in June 2003. Its aim was to explore the contingency plan in the event of an outbreak of Severe Acute Respiratory Syndrome (SARS) in South West England and Wales. The concerns raised in Shipshape remain as relevant today as they were in 2003, as the findings on key objectives demonstrate:

- 1. To explore the capabilities of local healthcare systems in coping with an increasing number of SARS cases.***

- There was a need to think about safety procedures and places for*

assessing patients.

- *Staffing resources would be problematical*
- *Should one hospital in the area be designated an infectious diseases receiving hospital? Should it be geared up now?*
- *There may not be adequate ITU bed capacity and protective equipment*
- *Decontamination advice will be given by hospital infection control teams who should have a policy in place - there is a trust-wide policy in place (Wales)*
- *There are health & safety issues around air conditioning units*

2. To explore control of infection guidelines, including isolation procedures and communication protocols.

- *Decontamination protocols (e.g. WHO/CDC) and all related issues to be dealt with subsequently by a taskforce*
- *Communications protocols apparently already exist between PCTs and SHAs, but were not readily apparent*
- *Guidelines may need revision, in light of exercise ...*

4. To explore contact tracing arrangements and co-ordination of data communication.

- *In a non-exercise situation, contact tracing would be very time and labour intensive. Who would carry this out?*
- *Consider strengthening staff training to cover contact tracing.*
- *Who holds the operational data? There needs to be an integrated national database at Colindale to provide information for WHO, SW Epidemiology and CDSC*

5. To identify resource requirements.

- *Does NHS have capacity?*
- *There is a need for surge capacity and relief arrangements*
- *Lack of personal protective equipment (in this context includes gloves, gowns and TB- quality facemasks).*
- *Clarify PPE stocks and ensure safe storage*
- *Look at emergency department capacity*
- *Look at ICU capacity [INQ000235217_0004].*

15. The CFBJ Cymru observe that, had learning from Exercise Shipshape been implemented, Wales would have been in a far better position by the time of the Covid-19 pandemic some 17 years later. Instead, there appears to have been no

learning whatsoever. As Anna-Louise Marsh-Rees, co-leader of CBFJ Cymru, said in her evidence to the Inquiry: “*there were a number of recommendations that were made, including being able to effectively contact, trace and isolate. Clearly none of that seemed to be taken on board in subsequent years*” [1/146/12]. Indeed, such was its perceived insignificance that the final report of Exercise Shipshape was disclosed by the Welsh Government one month after the conclusion of Module 1 (and thus was not addressed by the Inquiry during the public hearings considering preparedness in Module 1).

2009: Exercise Taliesin [Module 1 - INQ000128976]

16. Exercise Taliesin took place in April 2009. The aim of *Exercise Taliesin* was to test the Pan-Wales Response Plan and influenza pandemic plans by live exercise across Wales. Exercise Taliesin exposed a number of gaps in plans which “*need to be addressed ahead of a more serious pandemic*” [INQ000128976_0013]. Of particular concern was the social care sector:

Social Care

Although considerable progress was made in developing resilience within the social care sector during the response to swine flu further work is required to enhance the engagement with, and preparedness in, the independent care sector [INQ000128976_0014].

17. The de-brief recorded the following under the heading, ‘What Next?’:

The completed report will be circulated to all Local Resilience Forums for them to consider the outcome and the recommendations and to translate these into appropriate actions to further develop pandemic flu planning at the LRF and organisational levels. This will compliment the lessons learnt agreed in the individual LRF de-briefs and those produced for each LRF by Gold Standard. Individual agencies will also have their own de-brief reports to draw upon in this process.

The Wales Resilience Partnership Team will consider the recommendations which can be taken forward at an all-Wales level to help support local pandemic flu planning.

It is likely that a more detailed review of the swine flu response will be undertaken at all levels following the end of the pandemic. This will develop further recommendations to help improve planning [INQ000128976_0006]

18. None of this appears to have been done. The Wales Resilience Partnership Team agreed to set up the Wales pandemic flu task and finish group to consider recommendations from the 2009 swine flu pandemic. As confirmed in the oral evidence of Dr Andrew Goodall in Module 1, that group did not finish its task and the recommendations were not all fully implemented [13/95/9-10].

2013: the Pollock Review

19. A 2013 review called the Pollock review investigated why lessons were not being learned. As a result of that review, the Wales Learning and Development Group was formed, and a decision was taken to apply a Joint Organisational Learning strategy. Nothing happened.

2014 and 2016: Exercise Cygnus [Module 1 - INQ000187149]

20. Exercise Cygnus was the Welsh Government's pandemic flu exercise. The report in October 2016 'Exercise Cygnus – Wales De-Brief Report' [INQ000187149] set out a list of recommendations. Of particular note were the following:

Recommendation 1 - All organisations were asked to review their pandemic plans regarding health countermeasures to ensure they remained robust;

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

Recommendation 3 - All organisations to review their local delivery points and antiviral collection points to ensure they remained current and to share this information with Welsh Government

Recommendation 4 - The Pan-Wales Response Plan should reflect the fact that Welsh Government needs to establish a Battle Rhythm early for all situation reporting to assess the impact of any emergency on the LRF areas and set out clearly and early what information is required... [INQ000187149_0004-0007].

21. The Inquiry will recall from Module 5 that a failure to maintain adequate and in date stockpiles led to (amongst other things) inadequate supplies of PPE and a completely chaotic distribution system – such that local hospitals and care homes did not receive what they needed. The Wales Resilience Partnership Team delegated the responsibility of implementing recommendations to yet another body, the Wales Pandemic Flu Preparedness Group. However, the workstreams which were identified after Exercise

Cygnus in 2016 were not all fully implemented because the body designed to ensure implementation, the Wales Pandemic Flu Preparedness Group, did not sit after January 2018. Mr Drakeford in Module 1 explained that this was because resources were needed elsewhere due to Brexit planning. Such explanations lack substance: Wales has suffered from two decades of failures to implement recommendations from its learning exercises.

2016: Exercise Alice [INQ000001213]

22. Although Exercise Alice focused on England, it was attended by a representative of Welsh Government who, as such, would have been aware of the learning and recommendations. This is particularly relevant as the exercise examined the response to MERS-CoV. The following recommendations are of critical importance:

- *Develop a MERS-CoV serology assay procedure to include a plan for the process to scale up capacity.*
- *Produce a briefing paper on the South Korea outbreak with details on the cases and response and consider the direct application to the UK including port of entry screening.*
- *Explore the capability for contact tracing and quarantining of possible MERS-CoV cases:*
 - *Produce an options plan using extant evidence and cost benefits for quarantine versus self-isolation for a range of contact types including symptomatic, asymptomatic and high risk groups.*
 - *Develop a plan for the process of community sampling in a MERS-CoV outbreak.*
 - *Develop a live tool or system to collect data from MERS-CoV contacts.*
 - *Research, review and identify good practice for definitions for close-high risk contacts and recommend a definition for MERS-CoV.*
 - *Prepare a FAQ for MERS-CoV close/high risk contacts.*

2019: TTP scheme Llanelli

23. The Welsh health system had experience of a TTP scheme following the outbreak of a respiratory disease (tuberculosis) in Llwynhendy, Llanelli, in 2019. Mr Gething, in his evidence to the Inquiry in Module 2, described the system as follows:

we had a highly efficient contact tracing system and service for small to modest outbreaks. So I think I've given the example of the TB outbreak in Llwynhendy that

took place, and actually our contact tracing system there was really good and really efficient but actually the scale of what was required – that wasn't really contemplated as a learning point that was ever brought to me after Cygnus... [Module 2 11/47/12].

24. Similarly, Mr Drakeford in his Module 2 witness statement cited the TTP-type scheme for a tuberculosis outbreak in Llanelli as evidence that Wales has a “*pre-existing infrastructure that had served the nation well*” [INQ000575983_0017, §§59-62].
25. But Mr Gething and Mr Drakeford are wrong to point to this experience as a success story. A report by PHW into the management of the TB outbreak found that there were “*serious failings*” linked to contact tracing, with the result that “*infected people were unrecognised and developed active disease, passing the infection on to others*”.¹ Cases linked to the outbreak in 2010 continued to be identified in 2019.
26. The CBFJ Cymru are frustrated that exercises took place to no effect: recommendations were not implemented leaving Wales vulnerable when the pandemic arrived in 2020. In short, Wales’ starting point was wholly inadequate. It had no hope of scaling up effectively.

‘Scaling up’ testing in laboratories in Wales

27. As was acknowledged by the Welsh Government in its evidence to the Inquiry, Wales lacked the ability to scale up test and trace and effectively. The reason given was that Wales had not anticipated test and trace on the scale required by Covid-19. This explanation exposes a lack of preparedness. However, the CFBJ Cymru is also concerned to ensure that the decision-making of the Welsh Government as to scaling up is scrutinised. In particular, the CBFJ Cymru asks whether better use should have been made of existing testing infrastructure of PHW laboratories in Wales, in the period prior to the establishment of mass testing sites.
28. Here the evidence of Sir Paul Nurse and his Dunkirk metaphor is apposite:

We needed the big ships but we had to appreciate that they would take time to be put in place and that we had to do something before they could get in place, and they would probably always be a bit slower.

¹Llwynhendy Tuberculosis Outbreak external review report’, 2 December 2022, jointly commissioned by PHW and Hywel Dda University Health Board.

The little boats, on the other hand, such as the Crick, could produce, as I've explained, much more rapid turnover in getting the data back, and would be very essential at the beginning of a pandemic because if you don't know where the infection, is you can't actually take any ways of preventing it. So it's absolutely critical [4/12/7-18].

29. Sir Paul's evidence was that had the smaller boats - the laboratories which were directly connected to hospitals and care homes - been utilised effectively, they would have "easily managed" routine testing of health care workers and care home workers in the early stages of the pandemic. The effect, had this been done, would have been to protect healthcare workers and vulnerable patients alike.

...we could have scaled up to around 10,000 in a month if we'd had the money. And given what I've already said, there's nothing that special about the Crick except we were prepared to do it and to do it very quickly. That could have been rolled out, using our protocols, to 30, 40, 50, maybe more places in the rest of the UK. I'm guesstimating there, I haven't actually counted them, but I'm thinking of research universities and other research institutions.

So if you just do the simple maths there, you can see that, within a month or two, we could have had 100,000 to 200,000 tests which would be turned around every 24 hours, locally set up. And that, I think, would have been a very effective way of dealing with the early days of the pandemic [4/21/8-22].

30. PHW produced a witness statement in which they set out the testing capacity at the start of the pandemic, including 13 PHW laboratories. However, there appears to have been no consideration as to scaling up the use of these laboratories – as the Crick Institute envisaged – in the early stages. Given Wales' high rate of nosocomial infection, this would appear to have been a missed opportunity and the likely consequence of a complete failure to plan for such a scenario.

List of Issues 3: Key policies

31. This section sets out key concerns of the CBFJ Cymru in respect of the TTP Wales. The topic, in particular the testing aspect of it, lies at the heart of the CBFJ Cymru's concerns.
32. Despite numerous pandemic preparedness exercises in the last two decades (described above), the Welsh Government did nothing to build capacity in testing systems. And,

when the pandemic arrived, this unpreparedness translated to a refusal to recognise the value of testing and to ensure it was prioritised.

33. Concerns regarding different aspects of the policies are addressed below.

A. Testing

(1) Delay in recognition by the Welsh Government of the value of asymptomatic testing

34. The Inquiry has heard expert evidence about when the scientific community acknowledged asymptomatic transmission.
35. Professor Christopher Fraser, Professor of Infectious Disease Epidemiology, told the Inquiry that the evidence of asymptomatic transmission “*emerged quite clearly throughout February and March 2020*” [2/199/19-20]. And at paragraph 19 of his witness statement, he explains:

*During February 2020, after discussions with several colleagues, it became clear that it would be useful to model TTIQ in the context of the new virus... A **startling difference** [emphasis added] that became immediately apparent from case reports was that many people appeared to be infected by asymptomatic source cases; over 70% in the case reports from China CDC. I contacted a colleague in Hong Kong to discuss this and confirm the validity of the results, which he did. We also consulted the dashboard of the Singapore ministry of health. They found that whilst many people seemed to have asymptomatic source cases, these source cases themselves became symptomatic after a few days. This proved that transmission was likely happening before people became symptomatic. Our estimates rapidly converged on about **50%, half of all transmissions**, [emphasis added] coming from cases that were not symptomatic at the time of transmission [INQ000475153_0007].*

36. Sir Paul Nurse, director at the Crick Institute, told the Inquiry there was “*ample evidence, actually from very early on*” of asymptomatic transfer, citing studies from China, Hong Kong, Italy, the cruise ship Diamond Princess [4/32/16-19].
37. Professor Harries (PHE and UKHSA) supported these views and told the Inquiry:

...asymptomatic testing and the risks were completely understood, I think, in March...at the start of April...there was a particular study in the US, in the Seattle

care home, which gave a lot of strong evidence with very good data and denominator factors of asymptomatic transmission, and then PHE actually did what's known as the Easter 6 study...which gave us...homegrown UK figures for the first time, which were really robust...I think it was generally around April time...when the reality of the proportion of cases...of asymptomatic transmission was recognised [10/142/6-21].

38. The Seattle care home study referred to by Professor Harries is at INQ000224063. It was posted as an early release on the website of the Morbidity and Mortality Weekly Report on 27 March 2020, and formally published on 3 April 2020. The report found that once Covid-19 was introduced into a nursing facility, rapid transmission occurred, and that of the 30% of residents at a particular facility that tested positive, approximately half were asymptomatic on the day of testing.
39. The PHE Investigation of SARS-CoV-2 outbreaks in six care homes in London over the easter weekend (13-17 April 2020) found that of the 218 residents, 107 (49.1%) were SARS-COV-2 positive and of these 107 residents, 51 (47.7%) did not develop any symptoms during the two weeks before or after swabbing. 20% of the staff tested positive, of whom only approximately 20% were symptomatic [INQ000320602].
40. On 14 April 2020, the 'Go Science' advice confirmed that asymptomatic infection, "*is common and represents a large proportion of disease transmission...Intensive track-and-trace testing efforts, including of asymptomatic individuals, are thought to be core to the successful disease control efforts in South Korea, Hong Kong, and Singapore...*" [INQ000087177_0001-2].
41. This was the same date that Sir Paul Nurse and fellow scientists at the Crick wrote to Mr Hancock to urge asymptomatic testing of health care workers – a priority cohort given their potential exposure to the virus and given their proximity to vulnerable people:

We followed the Committee's debate on the adequacy or otherwise of testing capacity within the NHS, but were surprised that, as far as we could hear, no mention was made in that assessment, of the need to test asymptomatic or oligo-symptomatic individuals, be they health-care workers or patients. This is of great concern in view of emerging evidence that a high proportion of infections are asymptomatic, obviously entraining a high risk of transmission between and among HCW and patients...

...Our perception is that, at present, there is reticence about doing more widespread testing of health-care workers. It will clearly be expensive and yet another challenge for hospitals that are already under pressure. Some have privately expressed their concern that making a positive diagnosis in asymptomatic health-care workers who might otherwise continue to work will deplete staffing levels at a time of need. Whilst perhaps understandable, these concerns are not productive in terms of the overall goal of controlling the epidemic. Rather it will result in recurrent problems of seeding fresh outbreaks with staff absences and the potential for infecting non-Covid patients in the health-care environment. Importantly, we consider that these concerns can only be overcome by a clear central directive from you as Minister [INQ000587060_0001].

42. Mr Hancock told the Inquiry that 14 April 2020, the date of the Go Science advice, was the date from which the UK government started making decisions on an assumption of asymptomatic transmission [8/32/23-25].
43. The following day, on 15 April 2020, the Lancet published evidence [INQ000587051] outlining the case for routine testing of healthcare workers given asymptomatic transmission. The article reported:
- A study of asymptomatic infection on the Diamond Princess cruise ship showed 51.7% were asymptomatic at the time of testing;
 - China's National Health Commission recorded on 1 April 2020 that 78% of positive cases (in a study) were asymptomatic;
 - Healthcare worker testing could reduce in hospital transmission – 41% in Wuhan got it in hospital. At the Royal Gwent Hospital, approximately half the A&E staff tested positive;
 - There was a powerful case in support of mass testing of both symptomatic and asymptomatic healthcare workers to reduce risk of nosocomial transmission and asymptomatic testing was “critical” to pursuing an exit strategy [INQ000587051_0002].
44. However, Wales was much slower to take account of the serious risk of asymptomatic transmission within its decisions and policies, despite being aware of the dangers this posed to vulnerable people. For example, on 24 March 2020 in the Senedd, the former First Minister, Mark Drakeford warned, “...most people will experience a very mild episode of this illness...The problem is that while you are asymptomatic you could be passing the virus on to somebody who is much more vulnerable” [INQ000420992_0020].

45. On 29 March 2020, Public Health Wales advised that “[i]f new...or existing residents do not have any symptoms...there is no value in testing for the presence of coronavirus” [INQ000336344].
46. Mr Drakeford uses almost identical language in the Welsh Senedd:
 - a. On 29 April 2020, Mr Drakeford told the Senedd when asked about routine testing in care homes, that “*the clinical evidence tells us that there is **no value** in doing so.*”
 - b. On 6 May 2020, he similarly told the Senedd that he had not seen “*any evidence*” that asymptomatic testing had any “*clinical value*” in homes where there was no coronavirus in circulation.
47. Explanations for these bizarre statements were offered by Mr Gething - who referred to the “*cut and thrust*” of the debating chamber [6/166/16] – an unconvincing explanation given Mr Drakeford was clearly following the party line developed earlier in March, and then doubled down on the claim on 6 May. Dr Howe also attempted to defend Mr Drakeford by pointing out that the second statement in the Senedd was conditional on there being no coronavirus in circulation [9/129/9-17]. However, CBFJ Cymru submit that the views of Peter Halligan, Chief Scientific Advisor for Wales as expressed by Robert Hoyle (Head of Science for the Welsh Government Office for Science) are to be preferred. He wondered what “*the rationale, evidence and advice*” [PHT000000073_0046] was behind Mr Drakeford’s comments.
48. However one interprets these comments, one thing is clear: there was no change to the Welsh Government’s baseline flawed assumption until mid-May.
49. The Welsh Government point to the “*new*” SAGE advice of 12 May 2020 [INQ000587349_0048, §167] that extensive asymptomatic testing in care homes was *crucial*, to justify their delay in not introducing partial routine testing in care homes until 16 May 2020 (not expanded to all care homes until 15 June 2020). But this entirely misses the point – this was not new knowledge or advice at all as clearly demonstrated above.
50. The Welsh Government had the scientific evidence. Whatever the claimed difficulties in communication at Ministerial level, there was a high degree of collaboration between the UK CMOs, Chief Scientific Advisers and public health agencies. Thus, Wales would have been aware of the evidence in the scientific community, known by Professor Fraser, Sir Paul Nurse, Professor Harries, as referred to above, and in which respect CBFJ Cymru

asks the Inquiry to find that the scientific evidence was sufficiently strong as at 3 April 2020 (the date of publication of the Seattle care home study) to require government decisions and policy to be premised from this date on the assumption of very significant levels of asymptomatic transmission.

51. Further, the SAGE meeting minutes (at which the Chief Scientific Adviser for Wales was represented) demonstrate that the issue of asymptomatic transmission (and the related need for testing) was recognised throughout April and was not “new” advice on 12 May 2020, as claimed by the Welsh Government:
- a. 14 April SAGE 25 (the day of the GO Science report advising of the evidence of widespread asymptomatic transmission and that symptomatic-only based screening will miss cases) – at §§8-11: warning of significant transmission in hospitals and care homes and the need for increased testing in these settings.
 - b. 16 April SAGE 26 – at §§3, 31, and 33: *“Testing is an important part of controlling transmissions in hospitals and care homes”*; SAGE advises that the recommendations of the Nosocomial Working Group to reduce nosocomial spread should be adopted immediately in a coordinated fashion across all 4 nations, and *“SAGE advised that longer-term thinking on using separate sites for confirmed Covid-19 patients should be considered - as well as repeat testing of patients testing negative”*.
 - c. 23 April SAGE 28 – §§10-14: testing to commence of asymptomatic patients and staff and a testing strategy to reduce the spread in care homes is required.
 - d. 28 April SAGE 29 – §9: the proportion of cases acquired through nosocomial transmission may be increasing again. SAGE noted work underway to test new admissions to hospital as well as asymptomatic staff.
 - e. 30 April 2020 SAGE 30 – §§11-15: variation in levels of nosocomial transmission, with a rebound and persistent rise in some Trusts...significant transmission in care homes...a substantial surveillance system is needed to reduce transmission...A recent NHS study suggests a positive test rate among asymptomatic healthcare workers of 5-6%.
 - f. 5 May 2020 SAGE 33 - §2: *“SAGE advises that based on current data, focus should be maintained on reducing transmission in health and care settings. Urgent action should be taken in establishments where relevant measures are not already in place, in line with previous advice (such as avoiding movement of patients or staff between establishments, separating people as far as practical, and testing extensively)”*. This is the day before Mr Drakeford states in the Senedd (for the second time) that there was no clinical value in routine testing.

- g. 7 May 2020 SAGE 34 - §§1 and 14 “SAGE reiterated its advice that there should be extensive testing of healthcare workers including asymptomatic workers” and SAGE reiterated the importance of addressing the epidemic in the healthcare and care home sectors and reiterated its advice that there should be extensive testing of healthcare workers including asymptomatic workers as well as the application of other measures previously advised. SAGE participants offered to provide advice to the healthcare worker testing programme if required.
52. During the Module 7 hearings, the Welsh Government maintained that they did not delay the introduction of asymptomatic testing in care homes and that they responded promptly to the ‘new’ advice of SAGE on 12 May 2020. However, the evidence exposes this for what it is: an after the event corporate position statement that seeks to avoid criticism for delaying testing rather than a factually accurate account of what happened that would provide much needed answers for the families of the bereaved.
53. CBFJ Cymru believes that the most likely explanations for the failure of the Welsh Government to introduce routine testing sooner are because of a lack of testing capacity and concerns that such testing would require large numbers of staff to isolate leading to staff shortages (for both of which the Welsh Government bore responsibility). Blaming scientific uncertainty was a convenient means of avoiding this responsibility.
54. In the final analysis, and for reasons still yet to be fully explained, Wales was slow to acknowledge the risks of asymptomatic transmission and the value of asymptomatic testing. Whatever the reason, the delay undoubtedly calls into question the view expressed by Mr Drakeford in oral evidence that in Wales:
- we planned first and then we announced. And sometimes that makes us look like we were doing things later than was happening elsewhere, but I believe that our method was more effective [6/208/9-13].*
55. What was more effective, the CBFJ Cymru asks, about repeated delays in the implementation of essential safety measures which endangered the lives of so many of the most vulnerable people in Wales? Further, the Welsh Government was not planning how to implement routine testing in care homes before making that announcement in May 2020; it was denying that there was a clinical value to it at all.
56. The CBFJ Cymru made reference in its opening to the question posed by CTI in Module 2B, namely whether the Welsh Government’s position on asymptomatic testing was a

position that could have been genuinely or sensibly held. And the CBFJ Cymru suggest that it is abundantly clear from the evidence that it was neither

(2) Delays and failures in testing regime for priority testing groups

57. On 24 April 2020, the Welsh Government published its Covid 19 exit strategy: 'Leading Wales out of the coronavirus pandemic: a framework for recovery' [INQ000083221]. The strategy indicated that in order to understand the level of infection in Wales, the Welsh Government was stepping up its testing capacity and capability. However, the strategy contained no detail on how such testing capacity and capability would be accelerated. When asked about these deficiencies in the Senedd on 29 April 2020, Mr Drakeford reiterated Wales' focus on testing only key workers. And, in the same session, he added that to draw "*any value from testing non-symptomatic people, you'd have to do it every day*", which would "*take away*" tests from others that need the testing. Despite all the evidence given in Module 7, the reason for the Welsh Government's reluctance to test and their lack of focus on testing remains unclear.

58. The deficiencies of the Covid 19 exit policy underpinned wholly inadequate and delayed testing decisions, the most notable of which are as follows:

- a. The failure to test hospital patients upon discharge to care homes
- b. Delays to routine testing within care homes
- c. Delays to/insufficient routine testing among health care workers
- d. Delays to/insufficient routine testing of patients in hospital

a. The failure to test hospital patients upon discharge to care homes

59. Over 1,000 patients were discharged from hospital into care homes in Wales, prior to the introduction of testing on discharge on 29 April 2020. This practice seeded infections into vulnerable communities, and was exacerbated by the lack of PPE, testing, and effective treatment and equipment available in care homes. It continued notwithstanding concerns as to the vulnerability of care home residents raised in the Senedd on 3 March 2020 [INQ000321248] and reiterated by Care Inspectorate Wales on 8 April 2020 [INQ000198288 and INQ000396510].

60. Despite these concerns, and knowing the risks of asymptomatic transmission, the Welsh Government refused to introduce testing on discharge to care homes on 8 April 2020 because of insufficient testing capacity [INQ000551798_0089]. CBFJ Cymru disputes the legitimacy of this justification because the number of untested discharges to care

homes per day in Wales at this time was just 10.5 [INQ000271757_0008] and while testing capacity was not large (1000 tests per day as at 9 April rising to 1800 by 20 April [INQ000312371_0002 and INQ000253584]) there was sufficient from which to prioritise this small number of discharges having regard to the serious danger of asymptomatic introduction of Covid-19 into a vulnerable care home community.

61. Further, the introduction of testing on discharge in Wales was some two weeks after testing on discharge was introduced in England (on 16 April 2020), and this same delayed and reactionary process is repeated throughout the pandemic.
62. The Welsh Government issued an apology in its opening submissions in Module 7: *“there ought not to have been a delay between the 15 April 2020, when the risk came to the fore...and the ultimate publication of guidance on 29 April 2020”* [1/124/7-11]. However, no explanation for the delay has been provided.
63. Incredibly, this practice of transferring Covid-19 positive patients into care homes persisted into wave 2 in Wales, with patients judged to be ‘non-infectious’ being discharged from hospital without a negative test from December 2020 [INQ000262400]. While recommending the change in policy, the TAG statement acknowledged that *“there remains uncertainty around the period of infectivity for individuals infected with SARS-CoV-2”* [INQ000227902_0004]. Concerns about this policy were raised with Welsh Government via email by the Older People’s Commissioner for Wales, who wrote that *“this indicates that some risk would remain that individuals could still be infectious in this situation and could post a risk of an infection spreading in a care home or other setting”* [INQ000185049_0001].
64. This change in policy was implemented at a time when the number of deaths involving Covid-19 in care homes was increasing - notifications to CIW of deaths in adult care homes increased from 21 in October 2020, to 217 in December 2020, and nearly doubled in January 2021 to 417 [Module 6 - INQ000198645]. Given the huge increase in deaths in care homes during wave 1, this decision demonstrates reckless disregard to learn lessons, to recognise the risks for vulnerable care home residents, and to avoid the huge loss of life experienced in the second wave.

b. Delays to routine testing within care homes

65. The failure of the Welsh Government to provide routine testing in care homes is a matter of very great concern for the CBFJ Cymru and encapsulates everything that was

wrong about the approach of the Welsh Government to the pandemic, including a failure to take a precautionary approach to the risks of asymptomatic and aerosol transmission; inaccurate claims that testing had no value; numerous changes of policy; a lack of transparency; and delays in implementation, including in comparison with other UK countries.

66. Over this period, a member of the CBFJ Cymru, who owned and ran a care home in Wales, campaigned extensively for routine testing because of the risks of asymptomatic transmission. It was glaringly obvious to her as someone working on the front line that routine testing was essential. As elderly and vulnerable care home residents were falling ill and dying within 48 hours of becoming symptomatic, she pressed for further testing. PHW, who were supposed to provide the test, were often unable to provide testing quickly enough in the period between the onset of symptoms and death [INQ000587321_0010]. Her increasingly desperate messages to the Welsh Government in April and May 2020, included the warning:

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 going to be treated with the same importance as England (less than 9 miles from here)...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 [i.e. testing] is not important enough [Module 6 - INQ000598470_0002].

67. On 16 May 2020 the Welsh Government announced routine testing in care homes. No satisfactory explanation has been provided for why it took until 16 May 2020 to announce routine testing for residents of large care homes, and why it took until 15 to announce routine testing of residents in care homes of all sizes, as well as care home workers (as stated above the risks and grave consequences of not doing so were known from at least 3 April 2020).
68. Lack of testing capacity is an unsatisfactory explanation: it points to a chronic failure to plan and an inability to scale up effectively. It also leaves unexplained the consistent under-use of testing capacity in Wales throughout April, May and June 2020, as set out in the table below:

Date	Testing capacity ²	Actual usage	Percentage	Reference
09.04.2020	1,000	1,254	125%	INQ000312371_002
20.04.2020	1,800	1,033	57%	INQ000253584
05.05.2020	2,100	743	35%	INQ000530780
02.06.2020	9,500	2,400	25%	INQ000087992_012

69. Various explanations have been advanced to explain under-use of tests in Wales. The Welsh Government sought to suggest that under-use was a necessary feature of the system: *“you can’t run the [testing] system at full throttle every single day”* [6/182/10-11]. A further explanation was that some tests needed to be held back for *“some emergency in the Covid context where you will need some spare tests”* [6/182/7-8]. Finally, it was suggested that it was necessary to set aside some tests for non-Covid matters [6/182/18-19].
70. These ineffectual explanations do not properly justify why it was that in early May 2020, when infections and deaths from Covid-19 were at a peak, 65% of PHW testing capacity in Wales was left unutilised. To suggest that keeping tests for ‘some emergency’ or ‘non-Covid’ matter should take precedence over the lives of vulnerable care home residents is derisory and an affront to the many members of CBFJ Cymru whose family members died in Welsh care homes during this time.
71. It reveals a complete failure to take a precautionary approach to protecting the lives of older people in Wales. Mr Drakeford told the Inquiry he believed that the Welsh Government *“did take a precautionary approach. And then the question is: could we have taken a more precautionary approach? And I don’t think the evidence would have justified us in doing so”* [6/203/15-18]. The CBFJ Cymru disagree and submit that there is ample evidence before the Inquiry that routine testing of all staff and residents within care homes should have become Welsh Government policy much sooner.

c. Delays to/insufficient routine testing of healthcare workers

72. Experts recognised early on that routine testing of healthcare workers was, to quote Sir Paul Nurse, *“absolutely clear that was essential”* [4/40/25]. It would help prevent nosocomial infection and would maintain, rather than deplete, workforce levels. The

² Refers to daily testing capacity within PHW laboratories and in due course the Welsh share of testing capacity within Lighthouse Laboratories.

Inquiry heard similar evidence from Professor Kloer in Module 3: testing limited viral spread [Module 3 – INQ000475209_0005, §33].

73. In Wales, routine testing of healthcare workers was not announced until 4 December 2020 (following the usual pattern of two to three weeks after England, which announced on 16 November 2020). However, many Health Boards in Wales did not implement routine testing of healthcare workers until March 2021. Some were even later: Hywel Dda University Health Board took a phased approach to routine testing which commenced in February and was completed by July 2021 (albeit the majority of staff were tested by the end of March 2021) [Professor Kloer; Module 3 30/162/12-164/18]. Furthermore, whilst the policy mandated testing twice weekly, testing took place every five days.
74. Of course, lateral flow tests only became widely available in November 2020, but that does not explain (i) why greater use of existing capacity was not used to test before 14 December 2020, and (ii) more importantly, why even when lateral tests were available, routine testing took until March 2021 to implement, after wave two. Mr Gething told the Inquiry he “*was pretty frustrated at the lack of pace in the use of the tests*” [6/161/12-13]. He went on to say:

...having a phased rollout through areas is fine, but for it to take that long, isn't fine...when I make a ministerial choice, I expect the system to deliver on that choice...if it's not happening, then I can't do anything about it if I don't know, and I don't think Welsh Government officials were really properly sighted on it... [6/162/14-23].

75. At no stage, did Mr Gething offer any explanation as to why it took until March 2021 for the routine testing of healthcare workers to be implemented, preferring instead to attribute delays to the local health boards. Nor did he accept any responsibility for the complete breakdown in implementing Welsh Government policy decisions, or the related communication failures between Welsh Government and other public bodies.

d. Delays to/insufficient routine testing of patients in hospital

76. The Welsh Government announced testing of all patients on admission to hospitals on 3 June 2020 and again on 15 July 2020. Reminders had to be sent out to NHS Wales directors in September 2020 because the policy was not being implemented properly. And it was not until 28 January 2021 that the Welsh Government introduced repeat testing of patients every five days.

77. But problems in testing and repeat testing endured, notwithstanding reminders and notwithstanding new policies. The Audit Wales report of March 2021, 'Test, Trace and Protect, an overview of progress to date' reported:

1.18 PHW figures show that compared to the first wave of the pandemic, hospitals have been testing proportionately more patients on admission, increasing from 24% in the first wave to 54% in October, but there remains considerable room for improvement...Once tested on admission however there has been no regular testing during a patient's hospital stay unless patients have developed symptoms...

1.19 ...It has been clear that once an in-hospital outbreak occurs, spread of COVID-19 as a result of hospital transmission has...resulted in very poor outcomes for patients... [INQ000214244_0017].

78. The report concluded that nosocomial infections could have been reduced by more effective testing, including more frequent testing during a patient's stay. This much known is by the CBFJ Cymru as many of their loved ones fell victim to basic testing failures. More frustratingly, witnesses offered no explanation for such failures. Along with the failure in routine testing of healthcare workers, blame was simply laid at the door of the health boards.
79. There has been no attempt to explain why this was so. And of course, without insights or reflections, there is no hope for lessons learned.
80. In Wales, routine testing was introduced on admission with five days repeat testing for asymptomatic patients from 28 January 2021 [INQ000227387]. This was in contrast to the approach in England where repeat testing was every three days. However, many patients were not tested in accordance with that policy, waiting many more days for repeat testing. Some reported loved ones being sent home following an outbreak in the ward, in order that the ward could be cleaned, but without being tested; they died in their homes.
81. The experiences of the families provide valuable context for such policies. Their experiences demonstrate clearly the chaotic testing in hospitals throughout the pandemic:
- a. October 2020: Anna-Louise Marsh-Rees, co-leader of the CBFJ Cymru, recalls how her father was admitted to hospital for a routine operation and was tested for Covid on admittance. He was negative. He was moved six times in eight days, ending up in a ward in which 21 patients and 13 staff had Covid. He was

discharged without being tested again (hospital staff told him they only tested those being discharged to care homes). Neither he nor any of his family members were advised to take a test. He deteriorated immediately once home and had to be re-admitted to hospital one week later. He was tested on admittance and tested positive for Covid-19. Tragically, he died three days later.

- b. December 2020: another member recalls how her loved one was admitted to hospital in December 2020 (with a non-Covid related issue) and his health rapidly deteriorated. However, he was not tested for Covid until his fourth day following admission. Instead, he underwent a series of intrusive and invasive tests during that period before being tested for Covid, which returned as positive. He was discharged, without a further test, and died.
- c. December 2020-January 2021: Jane recalls how the GP told her he suspected both her parents had Covid. Her father went to hospital first, was tested on admittance and the test was positive. He was admitted to a corridor, before being moved to a cubicle. Tragically he died. Jane's mother went to hospital a few days later. She had a test on admittance and the test was negative. Jane was told her mother was fit for discharge and could be collected. Jane insisted she have three clear tests before she returned home. A few days later, she had a second test, which was positive, and she was admitted to a Covid ward. However, in the intervening period, she was permitted to wander freely in the (non-Covid) wards, without a mask, interacting with patients and no doubt (completely unknowingly) contributing to the spread of the infection within the hospital.
- d. February 2021: Theresa (who appeared on the 'Impact' video in Module 1) recalls how her mother was admitted to hospital for a non-Covid related matter. She was tested whilst in her ward, and the test result was negative. She was not tested until 10 days later, despite the policy to test every five days, and despite the ward (with patients in it) being closed due to a Covid outbreak. Her second test was positive. Tragically, she died a few days later having tested positive for Covid.

(3) Restricting access to testing to 'the cardinal three'

- 82. The CBFJ Cymru is also aware that testing criteria in Wales was limited to the three cardinal symptoms – fever, continuous cough and loss of smell. However, many people experienced a wider range of symptoms, such as headaches, sore throat, fatigue, nausea, diarrhoea etc. The Welsh Government's failure to acknowledge this broader range of symptoms in testing criteria, even as late as March 2021, would have led to countless instances of symptomatic people continuing to spread the virus. Exhibited to

the Module 3 witness statement of the CBFJ Cymru's co-lead, Anna-Louise Marsh-Rees, is a letter that her father (as a Shielding Patient) received from the CMO for Wales, Sir Frank Atherton, in October 2020 that states:

You will need to self-isolate if you develop one of the following symptoms, a new continuous cough, a high temperature, loss of or change to sense of smell or taste. You should also apply for a test online if you develop one of these symptoms.
[INQ000327639_0005]

83. Dr Howe acknowledged the possibility that this decision meant that people with the virus remained untested [9/117/4-9].
84. Like so many aspects of the testing regime, the decision making here demonstrates the very opposite of a precautionary approach in action. The Inquiry has heard from Professor Tim Spector that as early as March 2020, he and his colleagues had evidence that "*in the elderly aged over 75, acute confusion could be the only presenting symptom*" [INQ000575990_0004, §8].
85. Yet, despite Ministerial Advice dated 23 March 2021 that the "*current 3 cardinal symptoms together have a combined specificity of approximately 50%*" and that symptom criteria for public **access** to a test should be broadened [INQ000116616_0012-0013], the recommendation to the Minister was that "*national messaging should remain focussed on the 3 primary symptoms*" [INQ000116616_0001]. Undoubtedly this resulted in healthcare workers and patients, and care home workers and residents, experiencing symptoms but not realising that they should be tested and inadvertently transmitting the virus.

(4) Failure to meet testing targets

86. The ability to set clear targets for testing is plainly an important feature of any effective policy. However, the CBFJ Cymru are concerned at what appears to be a lack of communication between the Welsh Government and PHW regarding testing targets in Wales. The Minister for Health and Social Services, Vaughan Gething, had communicated in March 2020 the target of increasing capacity to 9,000 daily tests in Wales by the end of April 2020. However, when questioned by the Senedd Health and Social Care Committee in May 2020, Dr Tracey Cooper (the Chief Executive of PHW) insisted that this was not a target she was familiar with. The CBFJ Cymru question how

this can be the case, when PHW had briefed Mr Gething on 20 March 2020 of this capacity target of 9,000 tests [INQ000195536].

B. Tracing

87. The tracing programme was inadequate in Wales. It completely overlooked care homes, and there was no attempt to trace anyone that had been in contact with an infected patient or healthcare worker during a cluster outbreak. The proximity app, introduced presumably because of its anticipated value, had very low take-up levels.
88. A key concern held by the CBFJ Cymru is that contact tracing in Wales was halted in March 2020 and did not restart until June 2020, almost two months after the peak of the first wave in Wales on 12 April 2020.
89. In relation to paper-based tracing, restaurants and the hospitality industry in Wales regularly required customers to complete paper-based forms for the purposes of contact tracing, and the CBFJ Cymru wished to understand if this largely paper-based data was provided to, and used by, the Welsh Government or PHW in the tracing programme, and if so, how this data was shared and used. The CBFJ Cymru sought clarity on the voluntary nature of such systems and is concerned that the inefficiency and ineffectiveness of such schemes allowed the virus to spread further and contribute to the overwhelming second wave of Covid-19 in Wales.
90. In relation to the NHSX 'app', the CBFJ Cymru wished to know how this was used in Wales, how many people in Wales used the app, how the data was used and what procedures were in place following a close contact alert. In particular, the CBFJ Cymru raised three issues relating to NHSX that were of particular concern:
 - a. what consideration was given to the population in Wales who did not have smart phones or may have had challenges due to technological literacy, and limited internet access, such as with the older population and those living in rural areas?
 - b. why was the NHSX unfit for purpose in the healthcare setting? The CBFJ Cymru understands healthcare workers were notified when there was a Covid patient nearby, even if separated by a wall. Such features meant healthcare workers turned off the NHSX app. This would have defeated the purpose of contact tracing within the app, and would have put many lives at risk, particularly vulnerable people in healthcare settings.

- c. why was there a significantly lower uptake of the app in Wales than in England, as demonstrated by the map prepared by Professor Fraser [INQ000475153_0027, §74 (figure 1b)].

91. Despite three weeks of evidence, these important questions in relation to Wales remain unanswered.

Conclusion – the Whole System

92. In connection with an initial report by Independent SAGE in early May 2020 on ‘how can testing and tracing be successfully achieved’, Professor McKee asked, “*Can we take a whole systems approach to understanding tracking and tracing?*” [2/52/20-21]. Professor Fraser told the Inquiry, “[t]he whole system is important” [2/203/18] and Professor Buchan’s evidence was:

...testing is more than a test. It is a whole system. It is a system embedded in a community that requires tracing around people who test positive, the understanding of why that tracing is important, effective means of isolation, including support for people in isolation, to consider social and economic factors. That is, it’s a whole-community, whole-system approach [3/6/1-8].

93. This view was shared by SAGE as seen in the minutes from SAGE 53 on 27 August 2020:

The effectiveness of mass testing will depend on several factors including the proportion of the population tested; the frequency of testing; the ability of a test to identify true positives and negatives; the speed of results; and adherence to isolation. It is important to recognise that testing is one part of a system leading to isolation of infectious individuals and the whole system needs to work in order to achieve the desired aim (which would be to identify as many infectious people as possible and isolate them from contacts during the infectious period) [INQ000061561_0003, §18].

94. The CBFJ Cymru support these views. There is a crucial need for a system that is comprehensive, mutually reinforcing, and capable of being implemented quickly when needed – not one that takes months to establish while infections rage, putting lives at unnecessary risk.