Module 6 of the UK Covid-19 Inquiry

Written closing statement on behalf of the Covid-19 Bereaved Families for Justice Cymru (CBFJC)

Introduction

1. Care homes were one of the least safe settings in Wales during the pandemic, and residents were extremely vulnerable - excess deaths during waves 1 and 2 were approximately 100% and the research of Professor Shallcross and colleagues established that once residents became infected in wave one, there was a 36% chance that they would die [INQ000544928_0001].
2. This vulnerability was well known to the Welsh Government (WG). However, despite this knowledge, elderly people in Wales were neglected. Worse, the claims that WG prioritised elderly people is not supported by their actions, as demonstrated throughout this statement.
3. False claims have been made by WG in connection with their testing policy. In their oral closing statement to Module 6, WG state that it was scientific and medical advice that prevented sooner testing on discharge from hospital to care homes [Day 20/125:18] and, "*that decisions on asymptomatic testing were similarly based on scientific advice available at the time and not based on testing capacity*" [Day 20/126:3-5]. This is not the case. It was a lack of testing capacity and concerns about the impact on staff absences that prevented more widespread testing. Further, CBFJC's closing statement will demonstrate how WG consistently used, 'the science', both during the pandemic and at the Inquiry, as a ploy to evade challenge and accountability.
4. This closing statement is divided into four parts: testing failures; inadequate IPC and PPE; the de-prioritisation of elderly people; and the failure to prepare for the second wave.

First - testing failures

5. Testing decisions and policy in Wales were slow, dysfunctional, reactionary, and false statements were made to justify not implementing testing sooner.
6. Emails from Care Inspectorate Wales (CIW) following a meeting with WG on 22 April 2020 record that "*testing arrangements are fragmented and differ across Wales*", there is "*no central lead for testing*", and "*no one could answer the question who or what organisation is in charge*" [INQ000198307]. Similarly, Professor Khaw confirmed during his evidence that there was a disconnect between Public Health Wales (PHW) and WG at the end of April around some of the decisions [Day 6/144:19-21].
7. The WG's position on testing at the Inquiry has two key features. First, that the risk of discharging untested patients into care homes did not come to the fore until 15 April [Module 7 Day 1/124: 7-9]. Second, that it was not until 12 May that the balance tipped

in favour of a programme of testing asymptomatic care home residents and staff [Module 7 Day 12/164:3-8]. The WG maintains that scientific and medical advice precluded earlier testing in both these areas, as follows, "*General asymptomatic testing in care homes was not introduced before 16 May because the advice received up to that point by the Welsh Government was that the scientific evidence did not support it. You also heard in evidence that the advice relating to asymptomatic testing of all care home residents that was referred to by Matt Hancock in a Health Minister's meeting on 5 May 2020 was never shared with the Welsh Government at any level nor were its contents reflected in SAGE advice at that time*" [Day 20/126:12-21]. CBFJC submits that these positions and statements are false. Scientific evidence (including advice from SAGE) did not support WG's position, and there was widespread sharing of information between the UK Government and WG.

8. Testing on discharge and routinely in care homes was required because of the vulnerability of care home residents and the risk of asymptomatic transmission. In Module 7 Professors Fraser and Nurse told the Inquiry that the evidence of asymptomatic transmission "*emerged quite clearly throughout February and March 2020*" [Module 7, Day 2/199:19-20] through studies from China, Hong Kong, Italy, and the cruise ship Diamond Princess [Module 7, Day 4/32:16-19]. And Professor Harries said that, "…*asymptomatic testing and the risks were completely understood, I think, in March…there was a particular study in the US, in the Seattle care home* [INQ000224063]*, 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 an Easter 6 study* [INQ000320602]*, in the Easter weekend, which gave us…home grown UK figures for the first time, which were really robust…"* [Module 7, Day 10/142:6-18].

9. This evidence was not hidden from WG - it was publicly available and well understood. And it is clear that the First Minister, Mark Drakeford, was aware of the dangers to care home residents from statements made in the Senedd in March 2020: on 3 March 2020, "…*what we know about the virus is that its impact is more significant amongst older people and people's whose immune systems are already compromised because of other conditions. And those people are to be found in greater concentrations in residential and nursing homes*" [INQ000321248_0012]; and again on 24 March 2020, when Mr 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].

10. Given the extreme vulnerability of care home residents to Covid-19 infection, a proper precautionary approach demanded asymptomatic testing both on discharge from hospital, and routinely within care homes, at the earliest opportunity.

11. The WG decided against this precautionary approach and chose to prioritise what little

testing capacity it had elsewhere. But rather than own and explain this decision at the Inquiry, they have hidden behind 'the science'.

12. 1,088 patients were discharged from hospital into care homes in Wales, prior to the introduction of testing on discharge on 29 April 2020 [INQ000271757_0008], which seeded infections into vulnerable communities. The extent of this practice goes beyond the failure to identify asymptomatic infections and includes knowingly transferring patients, who had either tested positive or were suspected to be infected with Covid-19, into care homes, raising ethical issues, such as:
    a. The circumstances explained by the CBFJC impact witness, Alison Sibley [INQ000614374], whose mother, Rosalind Brockbank, was admitted to hospital on 4 March 2020 following a fall, and while there acquired and tested positive for Covid-19. Despite continuing to exhibit symptoms of Covid, and a physiotherapist recording in her medical notes that she was not fit for discharge, she was nevertheless transferred to a residential care home without a further test. She died from Covid-19 on 17 April 2020 after 11 days of deterioration following her discharge from hospital.
    b. An email exchange between the Association of Directors of Social Services Cymru (ADSS Cymru) and Swansea Council on 14 April 2020 [INQ000511731]: "*Swansea have experienced: 1) Discharge to dom care where we weren't informed that patient had been tested. Subsequent result of test was positive. Was back before we had much of a grip on PPE. Risked infection of a number of staff and other care recipients. 8 staff ended up in isolation. 2) Patient discharged to a care home. Were tested as positive. Not symptomatic. Care home weren't aware until after the individual died and GP turned up in space suit saying that they could see on the records that the individual was positive for covid infection…Having a meeting about the ethics of knowingly transferring infection into a care home setting later this week*".
    c. Email correspondence between Care Forum Wales (CFW) and WG on 2 March 2020 proposing to "*facilitate faster discharge from hospital and the use of care home beds to free up space in our hospitals…*" [INQ000183761].
    d. Concerns expressed by CIW to WG on 8 April 2020 in relation to proposed guidance advising and encouraging care homes to accept patients from hospital including those that might have Covid-19 whether symptomatic or asymptomatic, and querying how care homes could safely care for patients with Covid-19 and protect the other people living in the home [INQ000198288].
13. In respect of routine testing, WG refused to accept the need for routine testing in care homes to combat widespread asymptomatic transmission, despite a wealth of published scientific evidence by the end of March/early April 2020 that significant asymptomatic transmission was occurring (to which care home residents were particularly susceptible

and vulnerable). The UK Government was slow to respond to this risk but did at least recognise it by 14 April 2020 within GO-Science advice of this date that 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]. The UK Government went on to announce routine testing for care home residents and staff on 28 April 2020 (almost three weeks before WG, which delayed until 16 May).

14. Meanwhile in Wales, WG tied itself in knots trying to justify its lack of action, and the former First Minister, Mark Drakeford, made false statements in the Senedd when claiming on 29 April and 6 May 2020 that there was no clinical value in routine asymptomatic testing in care homes. On 16 May 2020, WG finally changed its position and announced routine testing in all care homes. However, this did not take place immediately and was of a one-off nature for residents. It was completed by mid-June 2020, but only after the huge loss of life experienced in Wave 1.

15. The WG claims that this change of approach could not have been taken prior to 12 May 2020 when 'new' advice was provided within the meeting and minutes of SAGE 35 that, "*extensive testing of both residents and staff is* ***crucial*** [emphasis added] *both in care homes which have reported cases and those which have not*" [INQ000215622_0002]. But this was not new advice at all. SAGE meeting minutes from 14 April 2020 repeatedly warned of significant transmission in hospitals and care homes and the need for increased testing in these settings. For example, at §11 of the minutes of SAGE 25 on 14 April 2020, "*SAGE advises that increased testing in these settings, supported by modelling, is important*". Further examples at SAGE 26, 28, 29, 30, 33, and 34 can be found within CBFJC's written closing statement to Module 7 at §51. The real reason that the WG introduced routine testing following SAGE 35 was not because the SAGE advice was new, but because it had become completely untenable to perpetuate further WG's false claim that there was no clinical value in asymptomatic testing.

16. It was blindingly obvious to those on the frontline from early in the pandemic that routine testing was needed in order to prevent and control transmission in care homes. The Inquiry heard from Helen Hough, the owner of a care home in North Wales, about its importance and her efforts to secure testing, including within her email to her assembly member and the Minister for Rural Affairs and North Wales on 1 May 2020 (which Ms Hough requested be shared with Mark Drakeford and Vaughan Gething): *"…without anyone being tested, we do not know who has it, and who does not, so the risk of transmission is exceptionally high, especially as we are discovering with this very new disease that people can be asymptomatic but still test positive, therefore we do not know who is carrying this into the building, and that is why COVID-19 is 'spreading like wild fire'*

in Care Homes…I do not know how long it is going to be before relatives of the deceased speak to one another and realise they are not being treated with the same importance as England (less than 9 miles from here) and as the Prime Minister of the UK want them to be treated. Relatives are assuming these tests are being carried out as they see it on their national news…and [would] be horrified to learn that the Welsh Government has decided it's not important enough" [INQ000598470].

17. Testing capacity in Wales in mid-March was just 500 tests per day across the whole country and only 15 tests per day were available to Welsh local authorities with which to test their social care staff [INQ000569773_0092]. By April, capacity had increased marginally to 1,000 tests per day on 9 April 2020 [INQ000312371_0002], 1,800 tests per day as at 20 April 2020 [INQ000253584_0001], and 2,100 tests per day by 29 April 2020 [INQ000501510_0003]. This lack of capacity was the real reason testing could not be introduced sooner and blaming scientific uncertainty is simply a convenient means of avoiding responsibility. This cynical approach is now clearly exposed at the Inquiry by the following evidence (set out chronologically).

18. Within the witness statement of Albert Heaney, it is stated at §309, "*I, along with policy colleagues in my directorate, was concerned at the conflict between expediting hospital discharge to create capacity, and potential risks arising by returning or placing people vulnerable to the effects of Covid-19 back into care homes. This was a very difficult situation where decisions could only be taken by considering what was known at the time. It was clear that if discharges were not made, hospitals would not be able to function effectively which would inevitably lead to increased deaths. In the absence of advice to the contrary from health experts, the Deputy Chief Medical Officer (Wales), Public Health Wales, and evidence regarding the possibility of asymptomatic transmission; while testing of all patients upon discharge would have been preferred, without sufficient testing capacity it was not possible*" [INQ000551798_0088-89]. Despite this clear and detailed account of Mr Heaney's wish to introduce testing on discharge but for a lack of capacity, Mr Heaney resiled from this position in his oral evidence to the Inquiry on 15 July 2025. While confirming that the capacity to undertake "*wider-base testing*" did not exist until May and June 2020, Mr Heaney explained that in fact the decision that he made on 8 April 2020 not to test all patients on discharge from hospital to care homes was based on "*medical and scientific advice*" and that the statement to the contrary made within his witness statement at §309 (quoted above) was Mr Heaney's view, "*in hindsight*" [Day 10/139:1-140:17]. While not doubting the sincerity of Mr Heaney's concern, CBFJC does not accept this explanation, and the attempt to reconcile the statement, "…*while testing of all patients upon discharge would have been preferred, without sufficient testing capacity it was not possible"* with the position of WG at the Inquiry that they were following the science, is not credible.

19. The preliminary findings of the Public Health England (PHE) Easter 6 study was shared with the UK Senior Clinicians Group (which included the Welsh CMO, Sir Frank Atherton and DCMO, Dr Chris Jones) "*as soon as these were available, in the week commencing 13 April 2020*" [INQ000309002_0023]. The PHE report of this study, titled, "The Easter 6 Care Home Investigation" [INQ000320602] found that of the 218 residents, 107 (49.1%) were SARS-COV-2 positive of whom 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.
20. Shortly after this meeting, on 15 April 2020, an email was sent from WG to PHW that stated, "*Just to alert you that CMO and Albert Heaney want a revised approach to testing in place asap which will include testing on hospital discharge to care homes and more general testing for care home residents and staff*" [INQ000520929]. CBFJC suggest that this request for testing on discharge and more generally in care homes was likely in response to the GO-Science report of 14 April and the PHE Easter 6 study.
21. The 15 April email was followed by an email exchange between WG and PHW on 16 April 2020 [INQ000598625] which states, "*CMO and Albert Heaney want a revised approach to testing in place asap which will include testing on hospital discharge to care homes and more general testing for care home residents and staff. They wish to communicate this tomorrow. As you can see from the numbers below there does need to be a significant increase in testing capacity to deliver on this given the commitment already given to LRFs to test key workers. Can you confirm that PHW are on track to deliver 2207 tests as of Monday 20th?*" To which, PHW replied, "*We are working to clarify our testing capacity, which is increasing sequentially over the next days and weeks…I'm not sure that there will be a significant mismatch between demand and capacity*".
22. PHW interpreted the WG emails of 15 and 16 April 2020 as, "*the Welsh Government's Social Care colleagues were relaying a message from the CMO and Albert Heaney, that they wished to write out to care homes and advise that Wales would also be testing patients prior to discharge and testing all symptomatic residents in care homes…[however] we still had not had any discussion with the CMO about this proposed change* " [INQ000587702_0057]. Further, Giri Shanker of PHW replied to Alison Machon (WG Head of Regulation and Inspection Policy) on 16 April 2020, as follows, "*I have not been involved in any discussions with CMO on this…I want to be very clear that (1) Just because PHE have changed their guidance, it does not mean we have to (2) If we were to follow the English guidance,* ***we certainly do not have the testing capacity to meet the revised requirement*** [emphasis added]" [INQ000617081].
23. At §203 of Professor Khaw's statement [INQ000587702_0057], it is stated, "*Andrew Jones from Public Health Wales had also attended a meeting with the then Minister for Health and Social Care and Local Authority Leaders on 16 April 2020, where the Minister*

for Health and Social Care presented a different position on testing based on CMO advice". This account is corroborated by the email of CIW of 16 April 2020 [INQ000501494] in which Gillian Baranski, the Chief Inspector, expressed her concern at Mr Gething's comments, "*Hello Frank, I was at a meeting earlier today with the leaders of local government and Vaughan Gething. Covid 19 testing for people discharged from hospital back to care homes was the main focus of the discussion which became quite heated. The Minister insisted repeatedly he was following your advice as CMO that asymptomatic people did not need testing before being released to care homes. There was much consternation expressed by the leaders of local government and I imagine there will be further and repeated discussion about this going forward. You will be aware of discussions we had last week with PHW colleagues when we voiced our significant concerns about this. We are aware that in England they will shortly be testing everyone released from hospitals to care homes (both symptomatic and asymptomatic)*". Either the CMO was instructing PHW to introduce testing on discharge while simultaneously advising Mr Gething that there was no need to do so, or Mr Gething had misrepresented the position. There is no witness statement from Sir Frank Atherton in Module 6, and his statement in Module 7 is noticeably silent on the issue of asymptomatic transmission over this crucial period.

24. An email between Mr Gething and Dr Rob Orford (Chief Scientific Advisor for Health) over the course of 16 April to just past midnight on 17 April 2020, to which Sir Fank Atherton was copied [INQ000530887], makes clear that Mr Gething knew that testing on discharge from hospital was being prevented because of a lack of testing capacity and not by reason of scientific and medical advice. Within this chain, Mr Gething states, "*I want clarity and an explanation about where we are, where we expect to be this week and at the end of next week. I will go out and do the public explaining but at this point I haven't been told why we had commitments that we cannot meet and I do not have a sustainable position to offer on increasing capacity and usage*" [INQ000530887_0005]. Mr Gething also specifically requested an explanation of, "…*the plan expected to deliver and when in April*", and for care home testing of staff and residents and the testing of care home residents on release from hospital to be added to the testing review [INQ000530887_0001]. Dr Orford's replies within the chain include notification of the extremely high rate of Covid-19 positivity within care home residents and workers (from what little testing was taking place in Wales) at 48% and 52.5%, respectively [INQ000530887_0003], and that Wales had managed to perform 1,000 tests on 15 April 2020 [INQ000530887_0004].

25. On 17 April 2020, Dr Orford provided a briefing note to Mr Gething [INQ000384410] that contains the following statements: "*Testing to tell you have coronavirus if you have the symptoms of COVID-19 is not that helpful,* ***unless you work with vulnerable people or***

patients [emphasis added]" [INQ000384410_0001-2]; "*In order of priority and areas of greatest need for testing are (1) Testing in healthcare and social care settings to reduce harm*" [INQ000384410_0002]; "*We know that we have [to] test more people in the healthcare setting, patients and staff alike as well as in the social care setting both residents and social care workers where greater harm may arise from infection*" [INQ000384410_0002]; "*Our initial plan to deliver five thousand tests a day has been hit by global supply chain issues…Two weeks ago, I committed further monies, to bring in further equipment and reagents to increase our testing capacity. We have not announced the additional tests per day that this will bring us as the media will crucify us again if we are late by a week…We have deliberately made different decisions about mass testing than others*" [INQ000384410_0003].

26. On 18 April 2020 PHW met with PHE to discuss the results of the Easter 6 study, a note of which meeting is at INQ000191663. Later that day, PHW held their own separate meeting to discuss ideas for a Wales approach and produced a note of this meeting [INQ000384504] that includes the following statements: "*COVID-19 has proved highly infectious in closed settings…once 3 or more cases are reported, there is around 50% prevalence in both staff and residents despite apparent use of PPE…most care homes will become affected over the next 6 weeks…There is also evidence of underreporting in deaths and of a rise in deaths in the care home setting…Possible measures to consider include: Prevention of entry into the home and more testing in staff, including asymptomatic*". This note was shared with the WG immediately (such was its significance) and prompted the drafting of Ministerial Advice.

27. Within an email chain over 17 to 19 April 2020 [INQ000384521], the following statements are made. On 17 April 2020, WG instructs that "*NHS Wales and PHW in support of the prevention and management of COVID-19 in care homes will provide the following: (1) Discharge testing to all patients being transferred from secondary care to care homes…(3) Rapid response to care homes who report possible case or cases…In support of the above PHW are requested to provide a brief paper on the mechanisms by which both staff and care homes will have access to prompt testing and support*" [INQ000384521_0004]. Then on 19 April 2020, Andrew Jones of PHW emailed WG colleagues, stating, "*clearly there are requirements of HBs and trusts e.g. in relation to patient testing prior to discharge and in using CTUs for testing of care home staff*" [INQ000384521_0002]. To which Dr Gillian Richardson (then Professional Advisor to the CMO) responded later on 19 April 2020 to PHW and WG colleagues, "*There have been 2 meetings also with England on Care Homes yesterday and one scheduled today which Chris Williams is attending from PHW. The situation is one which is rapidly emerging, as we now know that most Care Home infections are occurring through Staff. Where 2 resident infections occur in fact usually half of staff will have had Covid19 (many*

asymptomatic). Enclosing the meeting notes. Expect guidance will be issued formally soon". The two documents attached to this email chain are believed to be the note of the PHE/PHW discussion on 18 April 2020 [INQ000191663], and the note of the subsequent PHW meeting, also on 18 April 2020 [INQ000384504].

28. PHW produced a proposal for the management of Covid-19 in care homes on 20 April 2020 [INQ000520962]. This document includes the following statements, "*It is clear from experience within the enclosed settings cell and from recently completed epidemiological investigations in England that infection is widespread within care settings and that transmission within the settings is rapid and difficult to contain. Rapid, proactive and consistent action is required as soon as the first symptomatic case is identified.* ***Even in these circumstances the level of infection may already be significant among asymptomatic individuals*** [emphasis added]" [INQ000520962_0002].

29. On 20 April 2020 there was a Senior Clinicians Group Meeting, for which a PHE paper of the same date on the prevention of Covid-19 in care homes was circulated (including to Sir Frank Atherton). The paper states, "*By the time an outbreak is reported, the SARS-CoV-2 infection can be widespread in the home…Modelling suggests that the key vehicle for the spread is the movement of care home staff…public health advice is only likely to have a small impact during an outbreak and there may be greater benefits in supporting care homes to prevent introduction*" [INQ000348275_0005]. The paper lists potential measures in response including, an occupational health screening/testing for asymptomatic staff on a regular basis to pick up asymptomatic positive staff early and exclude them [INQ000348275_0007, and 0009].

30. At a meeting with Albert Heaney on 23 April 2020, Directors of Social Services queried when testing on discharge and asymptomatic testing of care home residents and staff would be implemented. CIW indicated that they wished to see these actions as soon as possible [INQ000198308].

31. On 23 April 2020 there was a Senior Clinicians meeting attended by the Chief and Deputy Medical Officers and Chief Nursing Officers from across the UK, including Sir Frank Atherton (Welsh CMO), Dr Chris Jones (Welsh DCMO), and Jean White (Welsh CNO). The minutes [INQ000068951] record an update on care homes that included the following statements by Paul Johnstone of PHE, "*There is a lot of asymptomatic transmission in care homes…Review of international evidence identifies effective actions including hand hygiene; environmental decontamination; staff rotation with staff allocated to one facility consistently; testing of care home residents and staff…symptoms are not good indicators of cases in elderly/care home residents*" [INQ000068951_0002]. The update on testing by Aidan Fowler (Deputy Chief Medical Officer for England) included the following information, *"[testing] capacity will be used for surveillance, and possibly symptomatic community testing, track and trace, and asymptomatic testing of all NHS and social care*

staff. But opening up testing too much may overwhelm capacity" [INQ000068951_0003]. A report authored by Mr Johnstone summarising the international and UK evidence on outbreak management in care homes, titled, 'COVID-19 in care home settings: Enhanced Prevention and Outbreak Management' [INQ000089662] was also considered at this meeting. This paper refers to the CDC [INQ000224063] and PHE Easter 6 studies [INQ000320602], and also a study from Singapore by Tan *et al*. The paper reaches similar conclusions to the GO-Science paper of 14 April 2020, and states "*there is asymptomatic transmission of COVID-19 in care homes among both residents and staff*", and "*by the time a single symptomatic case is identified in a home, the virus will already be circulating in the home amongst residents and staff"* [INQ000089662_0003]. The paper lists actions that are likely to be effective as advised by the UK Centre for Evidence Based Medicine from a review of international evidence, including, "*Testing of care homes residents and staff supports the home to rapidly respond and put additional measures in place to contain and prevent further spread*" [INQ000089662_0002]. The paper also states, "*Among countries that appear to have had success in preventing COVID-19 entering into care homes, such as Singapore and South Korea, there have been very strict processes to isolate and test all care home residents and staff who not only have symptoms, but who may have had contact with people who have COVID-19*" [INQ000089662_0003].

32. On 24 April 2020 Dr Chris Jones sent two emails to WG, PHW and CIW colleagues, captured within the email chain [INQ000336445]. The first timed at 10:29 states, "*This is the English care home paper, discussed with the UK Care Minister yesterday and senior clinicians last night*" [INQ000336445_0002] (believed by CBFJC to be Mr Johnstone's paper referred to in §31 above). The second is addressed to PHW colleagues, Andrew Jones and Julie Bishop, and states, "*I know you are currently working on revising the PHW guidance for residential settings in light of discussions over the last week and are also considering the attached PHE update document shared this morning. Albert Heaney is very keen that this is done urgently and guidance issued…Albert has also said he wants: "Global testing of residents; Staff testing addressed; Dom support work testing*" [INQ000336445_0002]. This email prompts a response from CIW that "…*all staff (and residents in care homes) should be tested whether they are asymptomatic or not and in truth these tests need to be repeated at regular intervals*" [INQ000198311].

33. On 24 April 2020 PHW produced updated draft guidance to prevent Covid-19 in residential care settings [INQ000395608]. Inexplicably, this guidance does not require a negative test upon discharge, and it advises that positive symptomatic patients can be discharged to a care home subject to isolation [INQ000395608_0004]. Further, the guidance allows for the testing of symptomatic residents only, and states, "*Where capacity allows further testing of residents will be undertaken"* [INQ000395608_0008]. At §227 of his witness statement, Professor Khaw describes the reasons for this approach

as, "*the guidance was drafted to reflect this pragmatic approach while the system scaled up capacity…PHW's concern was…without any clear indication of prioritisation in situations where capacity had not yet been scaled up, would have put people at greater risk*" [INQ000587702_0064]. At §230, Professor Khaw further explains the difficulties encountered as, "*Welsh Government Officials were requesting changes to Public Health Wales guidance, which were not wholly consistent with the formal Welsh Government policy communications at the time*" [INQ000587702_0065].

34. On 25 April 2020 Professor Sir Chris Whitty emailed colleagues "*I was v struck by this paper from NEJM yesterday. It's from the US and not strictly comparable, but I think gives some feel for the burden of asymptomatic carriage*" [INQ000229085_0001]. The paper referred to was published on 24 April 2020[1], and concludes that, "*More than half of residents with positive test results were asymptomatic at the time of testing and most likely contributed to transmission*".

35. On 26 April 2020 guidance was provided by DHSC Social Care Testing Cell [INQ000478887], which includes the following information, "*The continuing growth in testing capacity has opened up new opportunities for testing targeted at particular priorities, including - in particular circumstances - testing of individuals not exhibiting symptoms. This has been enabled by a change in Public Health England guidance (approved by the Chief Medical Officer) this week, confirming that there is no barrier to testing asymptomatic people where clinically appropriate…Used in the correct circumstances, testing of asymptomatic individuals can have a number of benefits, including: - Developing understanding of prevalence and incidence of infection and how both change over time. - Exploring key vectors of transmission and effectiveness of public health interventions. - Supporting infection control, providing an ability to proactively identify those who are yet to develop COVID symptoms*" [INQ000478887_0001-2].

36. On 28 April 2020 Alison Machon emailed PHW [INQ000520936_0001] and expressed dissatisfaction with the draft PHW guidance of 24 April 2020 [INQ000395608], stating that it "*is not consistent with the 2 letters issued by the Deputy Director General* [Albert Heaney] *and CMO* [Sir Frank Atherton] *last week, the paper on care homes from PHE last week which identified two sources of infection as staff and hospital discharge…**It also doesn't pick up on the areas Albert has asked to be addressed in terms of global testing of care home residents and staff testing including to identify risk from asymptomatic staff*** [emphasis added]*"*.

37. In a separate email of 28 April 2020 [INQ000396501], Ms Machon communicated the above dissatisfaction to Mr Heaney and Sir Frank Atherton, to which Sir Frank replied, "*I*

[1] Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility, New England Journal of Medicine: https://www.nejm.org/doi/full/10.1056/NEJMoa2008457.

thought we had agreed to test all hospital discharges and all ***symptomatic*** *residents and staff but not asymptomatics*" [INQ000396501_0002]. Within this chain, once again, CIW advocate strongly in favour of regular asymptomatic testing, stating, "*the idea of asymptomatic staff and residents spreading the virus would be an unacceptable risk*" [INQ000396501_0002].

38. On 28 April 2020 PHE circulated an options paper by email [INQ000396502_0003] to PHW that advised of DHSC's intention to roll out "*regular* ***screening testing*** *of ALL residents and staff in care homes, regardless of whether they have symptoms or signs suggesting COVID-19 infection".* PHE's email and options paper was subsequently forwarded the same day to WG colleagues, including Sir Frank Atherton, Dr Gillian Richardson, Dr Chris Jones and Albert Heaney [INQ000396502_0001-2]. The options paper [INQ000500175] includes the following statements, "…*the care sector is seeing a large number of cases and outbreaks. One-third of care homes (4,300 in total) have now reported cases or outbreaks of COVID-19; these outbreaks have been associated with mortality of up to 40%*" [INQ000500175_0001] and, "*There are significant organisational issues where a high proportion of staff screened test positive, and asking them to remain off will likely mandate reliance of agency staff…*" [INQ000500175_0002]. On the same day (28 April) at a meeting between UK Health Ministers, Matt Hancock, Vaughan Gething, Jeane Freeman and Robin Swann, Mr Hancock provided an update on testing, including the asymptomatic testing of people in care homes [INQ000279763_0002]. As is apparent, there was extensive sharing between UK governments of information on testing policy both at Ministerial and Senior Clinician level, and suggestions by the WG to the contrary are simply an extension of their strategy at the Inquiry to obfuscate and to blame others.
39. 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*** *[emphasis added] in doing so*". CBFJC consider it likely that Mr Drakeford's inspiration for this choice of words is an email of Tracey Cooper of PHW from a month earlier, on 29 March 2020, when responding to an email from a Welsh Assembly member, Darren Millar [INQ000336344]. Mr Millar had asked when routine testing of new residents would begin given the vulnerability of care home residents, to which Ms Cooper provided advice (known to be incorrect even then) that, "*If new residents (or existing residents) do not have any symptoms prior to admission, there is no value in testing for the presence of the coronavirus*". This response was brought to the attention of Dr Andrew Goodhall (Director General Health and Social Services) on 30 April 2020, who commented, "*given broader questions about care homes and testing this is a helpful reference point for current testing regime*" and brought it to the attention of Mr Gething to be similarly deployed.
40. A notebook entry of Jane Runeckles (SPAD) [INQ000327608_0032-0033] records a meeting between Mark Drakeford, Vaughan Gething, Sir Frank Atherton, Dr Rob Orford,

and Dr Chris Jones on 30 April 2020. The entry records that Sir Frank Atherton and Dr Orford indicated that the approach is to test all that are symptomatic, and that it is not possible to test all 25,000 people in care homes every four days. Dr Orford indicated that some people are infectious before they are symptomatic, and begged the question, "*is there an argument for testing asymptomatic*". Dr Jones suggested that further testing will not tell them any more, and that the approach should be to assume everybody is positive and treat them accordingly. Mr Drakeford remarked, "*what difference does it make to how you are running the care home. Testing gives you information but not a solution*". The CBFJC make two observations about this meeting. First, it is clear that the reason for not proceeding with asymptomatic testing in care homes is because of a lack of capacity (25,000 people every 4 days) and not based on scientific and medical advice (as WG continues to suggest). Second, given the wealth of information within the knowledge of WG at this date about the need for asymptomatic testing to control infections in care homes, the level of ignorance demonstrated by these most senior decision makers in WG, typified by the statement of Mr Drakeford, "*what difference does it make…*", is astonishing.

41. On the same date, Albert Heaney (who is not indicated to have been present at the meeting on 30 April 2020) caused an email to be sent to NHS Wales colleagues that states, "*Albert Heaney has asked that we provide you an update on Care Home Testing policy for committee today. See attached a draft position paper setting out current status. Claire Rowlands is developing a fuller paper for the FM by this evening, on testing which will include options for expanding testing for asymptomatic individuals as announced by UK Government earlier this week*" [INQ000501509].

42. Also on 30 April 2020, Claire Rowlands, who since 18 April 2020 had been working on a Ministerial Advice on testing policy, following the advice of PHW from 18 April 2020, sent an email to Sir Frank Atherton [INQ000367481]. This email sought Sir Frank's approval for recommendations in the draft Ministerial Advice, including the following statement, "*Discussions with colleagues in Welsh Government and PHW indicate that testing of asymptomatic (or reportedly so) care workers would help to prevent introductions into care homes, and also provide an estimate of community incidence of COVID, and so targeting testing in the following ways (and this is being explored for health care workers): a. Serial testing of care home workers in care homes free of Covid-19. That would involve testing all care home workers in around 700 homes as it currently stands. This would need to be modelled and take time to get up and running…*" [INQ000367481_0001]. Approximately 30 minutes later Ms Rowlands emailed Sir Frank Atherton again, and stated, "*Just seen your other email Frank, so will remove the serial testing bit…*" [INQ000367483]. CBFJC have not been able to locate Sir Frank's reply to email INQ000367481. However, it seems clear that the CMO requested that the scientific advice, that asymptomatic testing of care workers would help to prevent the introduction

of infection into care homes, be removed from the Ministerial Advice. Again, CBFJC have two observations. First, Sir Frank Atherton was in receipt of a wealth of information from the UK Government, PHE, PHW, and his extensive engagement with UK counterparts to know that asymptomatic testing would help reduce infection in care homes. Second, it is reasonable to infer that it had already been decided in advance not to proceed with asymptomatic testing, and the direction to remove reference to the scientific advice in favour of asymptomatic testing was for the purposes of enabling that predetermined outcome.

43. The Ministerial Advice dated 30 April 2020 that was formally submitted for decision [INQ000336477] includes the following statements: "*We also intend to increase testing within care homes as more testing capacity becomes available*" [INQ000336477_0002]; "*There is some evidence to suggest that there are asymptomatic residents who are undetected and be a source of infection: A pilot study recently undertaken by PHE in six care homes in London…results from one care home…75% of residents were positive for COVID-19 but only 25% were symptomatic. 50% of staff were positive but only 29% of these were symptomatic; and a study by the [CDC]…Twenty-three (30%) residents tested positive, of these, 10 (43%) had symptoms on the date of the test and the remaining 13 (57%) were asymptomatic. Seven days after testing, 10 out of 13 of the asymptomatic residents had developed symptoms. This study suggests that symptom-based screening in long-term care facilities could fail to identify approximately half of residents with COVID-19*" [INQ000336477_0004]; "*Modelling suggests that we would need to [sic]* ***25000 extra test per week*** *for care homes to be able to test all residents - that doesn't include care home workers*" [INQ000336477_0004]; "*New evidence from England supports a targeted testing at care homes with outbreaks and larger care homes…Expanding into asymptomatic individuals still lacks the evidence base to support this being the best use of testing capacity*" [INQ000336477_0005-6]. The information within this advice, in particular the findings of the PHE study, makes plain the urgent need to test within care homes asymptomatically and that the reason this cannot be implemented is because of a lack of testing capacity. The suggestion of a lack of 'evidence base' is absurd and is inserted to provide cover for the fact that essential safety measures could not be implemented because of a lack of testing capacity.

44. The WG knew that the case in favour of asymptomatic testing was even stronger than that set out within the final Ministerial Advice, and this does not simply relate to the deletions instructed by the CMO on 30 April. Until at least 29 April 2020 (the day before the advice was finalised) the draft Ministerial Advice contained the following accurate reflection of the scientific position: "*our current policy in Wales is to test all symptomatic residents and staff…Evidence suggests that this approach results in asymptomatic Covid-19 individuals, many of whom will go on to develop symptoms, not being identified and a source of ongoing risk to residents and staff…International evidence suggests that*

increasing testing in care homes for asymptomatic staff will provide added protection against the virus in the sector" [INQ000367477_0007, and 0009]. CBFJC has not been able to determine on whose direction this accurate statement of the science was removed from the Ministerial Advice. It is possible that it was again the CMO, but whoever, CBFJC can only surmise that it was removed to aid the impression that the decision of the WG had some sort of scientific and medical legitimacy, whereas the reality was WG knew full well that they ought to be testing asymptomatically but simply did not have the capacity.

45. In contrast to the approach taken by WG, a WhatsApp exchange [INQ000102062] between Professor Whitty, Sir Patrick Vallance, Matt Hancock, Boris Johnson and Dominic Cummings on 3 May 2020 demonstrates their collective knowledge of the importance of testing in hospitals and care homes at this date, and includes the following statements: "*I don't understand why we are still not testing more NHS staff and care home staff including asymptomatic…we know the most vulnerable are in hospitals and care homes*" (Cummings); "*We should be and we have said that*" (Vallance); "*We have been doing this for the past week"* (Hancock); "*On testing in care homes and hospitals everyone agrees now we have the capacity we should be doing a lot more. It's not a panacea but it would definitely help*" (Whitty) [INQ000102062_0001-2].

46. Whereas in Wales, undeterred by the clear evidence within the Ministerial Advice of 30 April 2020 of the risk to life of asymptomatic transmission within care homes and the need for asymptomatic testing in response, Mr Drakeford doubled down on the false claims made a week earlier, and on 6 May 2020 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. These views are of course absurd, and they were known to be so at the time. Peter Halligan, Chief Scientific Adviser for Wales, caused an email to be sent to Dr Rob Orford and Fliss Bennee on 30 April 2020 upon hearing them on the first occasion, which reads, "*Dear Rob, Fliss, Peter Halligan is keen to understand the rationale, evidence and advice behind the First Minister's comments last night on the telly that there is no value to testing for Cov-19 in care homes. Please can you enlighten us.*" [PHT000000073_0046].

48. Further, the statement made in the Senedd on 6 May 2020 by Mr Drakeford was directly contrary to the following statements that asymptomatic testing did have clinical value, made within the Ministerial Advice of 30 April 2020, as follows: "*Discussions with colleagues in Welsh Government and PHW indicate that testing of asymptomatic (or reportedly so) care workers* ***would help prevent introductions into care homes*** *[emphasis added], and also provide an estimate of community incidence of COVID*" [INQ000336477_0005]; and "*If more on prevention side, testing which shows asymptomatic carriage,* ***could potentially prevent outbreaks*** *[emphasis added] by screening all homes*" [INQ000336477_0010]. In these circumstances, the statements

made by Mark Drakeford raise a serious question about whether the Senedd was deliberately misled.

49. Mr Drakeford was not alone in making such false statements. During a question-and-answer session on 23 June 2020 (reported at INQ000587938, and also publicly available on video[2]) Mr Gething was asked the question, "*The Welsh Government has said that the scientific advice was it would not be a good use of testing capacity to test asymptomatic patients until the end of April. If it was the case that there was a lack of testing capacity that caused this advice, was it the fact that there wasn't enough tests that meant you made the decision to not test people who were going into care homes until the end of April?*" To which Mr Gething responded, "*No…we based our decisions on advice and evidence*". The journalist continued, "*Surely if you'd had enough tests to have been able to test everyone, you should have been testing everybody who went from a hospital into a care home. And it was the fact that you didn't have enough tests that made that advice the advice that it was at the time*". Which elicited a similar response from Mr Gething, "*No…you're just wrong…if we had treble the amount of testing capacity…then that was still the evidence and advice that we had…we didn't get advice that said, 'you really should do this but you can't because you don't have testing capacity'*". CBFJC suggest that the evidence above establishes that a lack of capacity was precisely the reason that asymptomatic testing was not introduced sooner in Wales, and that the public statements made by Mr Gething in his capacity as Minister for Health and Social Services on 23 June, were not accurate.

50. Against this background of dithering, false statements and U-turns, it was difficult for bereaved families in Wales to hear the explanation offered by Mr Drakeford, in his recent oral evidence in Module 7 that, "*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*". What was more effective, the group 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, WG was not planning how to implement routine testing in care homes before their introduction on 16 May; it was denying that there was any clinical value.

51. Even once asymptomatic testing within care homes was finally introduced on 16 May 2020 the guidance issued was confused and contradictory. The statement of Vaughan Gething of 16 May 2020 [INQ000182446] stated that testing will be offered to all symptomatic staff and residents who have never tested positive before, with "*testing to be rolled out to all care homes in a matter of weeks*" [INQ000182446_0002], i.e. not

[2] Available online at: https://www.pscp.tv/w/ezWTDDFQWEtkcVlYUE12amV8MUJkR1lucGxlUXpKWLE3rNHhjq9n66M2-KewIRuVYm1X1irTs17IPwFADyn2?t=fRzf-wyHbUrKP8mCtK_gLQ&s=03

immediately. Thereafter, Sir Frank Atherton and Albert Heaney issued a letter to care home providers on 20 May 2020 [INQ000500188] to inform that rapid testing would be undertaken in care homes registered for 50 or more beds within the next two weeks, and that the testing of staff and residents in smaller care homes who do not have a Covid-19 infection will be delivered either by the relevant health board or through the new social care portal, "*which goes live shortly*" [INQ000500188_0002]. The target date for completing testing was 14 June 2020 [INQ000221150] which indicates that this was a one-off rather than repeat testing of residents. On 9 June, Vaughan Gething announced that care home staff would be offered a weekly test for a four-week period from 15 June 2020 [INQ000198394], which was extended in July [INQ000227202], and scaled back to fortnightly from 6 August 2020 with a review in October 2020 [INQ000368201].

52. What this amounts to is one-off asymptomatic testing of residents in care homes between the end of May and 14 June 2020, and thereafter routine testing of care home staff from 15 June 2020, all of which occurred after the first wave and too late to make any meaningful impact. A pathetic response from an incompetent government that failed to communicate the truth of what was happening to the people of Wales.

53. Further evidence that the clinical value of asymptomatic testing was well understood within WG and PHW can be found within the witness statement of Professor Khaw [INQ000587702, §218] in which reference is made to a Journal of Public Health article of 15 May 2021 [INQ000520960]. Although this article was not published until 2021, the findings were based on data collected from care homes in Wales between February and May 2020, and of the six authors, five are PHW scientists. The article finds, "*The delayed and lack of testing early in the outbreaks and delays in isolating residents before they became symptomatic are both likely contributing factors to the extensive transmission of COVID-19 in these homes*" [INQ000520960_0006], and "*Care homes should be enabled to take proactive steps to prevent introduction and transmission of COVID-19, including restricting visitors, universal testing, and isolation of residents as required. Waiting for identification of the first case before taking action does not appear to be a sufficient strategy for preventing an outbreak*" [INQ000520960_0006].

54. This, coupled with the need for adequate IPC, including PPE, RPE, and ventilation, is the key lesson of the awful experience of the pandemic for reducing transmission among elderly vulnerable people in care homes. CBFJC submit that it is clear from the evidence set out above that WG and PHW knew from early to mid-April 2020 of the need for widespread asymptomatic testing in these settings, and that reason it was not implemented was not because the science did not support such action until 12 May 2020, as WG claims, but simply because of insufficient testing capacity. What so incenses the members of CBFJC is that the continued false claims of WG that the policy was based on science and not a lack of capacity is for the purpose of evading responsibility, and in

doing so not only does it demonstrate a lack of integrity and accountability, it risks failing to learn from past mistakes. If the truth is acknowledged, it will be clear that better preparation could have avoided the severity of the impacts of the pandemic, but unless this is done, we are destined to repeat the same mistakes. The tragedy of the approach of WG is that it puts the reputations of a small number of Welsh politicians above the wider public interest.

Second - inadequate IPC and PPE

55. The numerous delays and failures in testing care home workers and residents meant that infection prevention and control (IPC) became even more vital to prevent the spread of Covid-19 within care homes in Wales. However, the reality was that many Welsh care homes were small, and their physical infrastructure created problems implementing IPC measures, effectively isolating residents and ensuring proper ventilation.

56. The Inquiry heard that WG's practice of discharging patients from hospitals into care homes without testing was taking place "*at a time when [PHW was] really clear that isolation provided an additional control measure, so that in the case of any positive or infectious individuals, we were able to also, through that measure, control transmission in that setting*" [Day 6/130:20]. However, this approach failed to take into account that isolation was not always possible in many homes, in particular where residents had dementia. In response to a question from the Chair, Professor Khaw acknowledged the "*real-life situation*" and difficulties for care homes: "*Technically, theoretically, isolation is a good control measure. But practically speaking, in care homes, particularly smaller care homes with highly vulnerable populations, it is difficult. I accept that*" [Day 6/131:15].

57. PHW purported to be "*familiar with the care sector's constraints in some of the care home environments*", and capable of providing "*practical advice on how [a care home] might… maintain infection prevention and control*" [Day 6/113:15]; however, CBFJC question the quality and feasibility of the advice provided to care homes when control measures such as isolation were - practically, rather than theoretically - very difficult to implement.

58. Another control measure, ventilation, was a huge challenge for many care homes and there was a marked lack of support and guidance from WG to help care homes improve their ventilation and air quality. Reflecting on the pandemic response, the CMOs and DCMOs highlighted in the UK-wide technical report that air quality in care homes is not currently well understood, but that it is key to mitigating the impacts of acute respiratory infections in future pandemics [INQ000101642_0303].

59. Professor Rayner, on behalf of the National Care Forum, told the Inquiry of the report commissioned from Eric Fewster, an Independent Water and Environmental Manager, who advised in April 2020 that natural ventilation (opening doors and windows) may not provide the ventilation rate required to significantly reduce airborne transmission risk even in summer, and with windows closed (i.e., during winter months), the only reliable

way of reducing the risk of airborne transmission was to install a mechanical system, such as a ventilation system and/or a recirculating HEPA air filtration system [Day 4/112:14].

60. However, Helen Hough told the Inquiry that her care home did not have a ventilation system, which became more of a problem coming into the second wave: "*By winter, we knew that ventilation was crucial, but we could not keep doors and windows wide open*" [INQ000587639_0015, §69]. Nor did her care home have any HEPA filters and "*[i]n fact, there was never any discussion around HEPA filters within the care home sector – whether before the pandemic or in early 2020…the sector was not at all prepared for an airborne pandemic*" [INQ000587639_0015, §69].

61. The value of HEPA air filtration was recognised in a Summary Brief by the Welsh Technical Advisory Cell (the body that coordinates scientific and technical advice to support WG decisions makers) in July 2020, which stated: "*Control Measures for Airborne Infection: SAGE EMG has already considered that the virus could be transmitted through airborne routes and has included this in relevant papers on transmission and recommendations for mitigating risk…**Good ventilation is well recognised as a primary measure for controlling the risk of airborne disease transmission**. A well ventilated space reduces the concentration of viral load in the air and hence the probability of infection…Evidence to date suggests that poorly ventilated spaces pose the highest risk, so it is recommended that mitigation measures focus on those spaces where ventilation is absent or inadequate…The use of recirculating air cleaners may be appropriate in small spaces where ventilation is poor and cannot be easily improved. **Devices which use HEPA or UV-C are likely to be the most effective**…Ensuring good ventilation of buildings is a particular concern for winter, where cold/adverse weather means that ventilation rates are often reduced to manage thermal comfort [emphasis added]*" [INQ000311892_0047-49].

62. Professor Beggs in his evidence in Module 3 highlighted the study by Conway Morris *et al*, from 22 September 2021, which showed that the use of supplementary HEPA filter air cleaning devices on a hospital ward was associated with greatly reduced SARS-CoV-2 RNA levels in the air [INQ000474276_0057], and in his recommendations, Professor Beggs commented that "*The evidence base in support of portable HEPA devices, in particular, is reasonably strong, since these perform a similar task to mechanical ventilation systems, and as such are a mature well-established technology that is quick and relatively inexpensive to deploy*" [INQ000474276_0013].

63. Despite the clear recognition that Covid transmitted via the airborne route, and that HEPA air filters were a cheap and effective mitigation, there was no support for or recommendations to care homes in Wales to utilise HEPA air filtration coming into the second wave.

64. Other aspects of infection prevention and control were impossible to implement within a

care setting. For example, the guidance that staff distance themselves by two metres from residents was totally unrealistic. Helen Hough said in her evidence: "*It's impossible. To begin with, you can't move anybody on your own. You can't nurse a patient without touching them. But also, you need two carers*" [Day 2/111:10].

65. And a modelling study into SARS-CoV-2 outbreaks in English care homes noted the limitations of its work because it did not consider the effect of staff absence on rates of transmission, which were likely to increase due to remaining staff being overstretched and therefore more likely to carry out sub-standard IPC.[3]

66. Because social distancing and other IPC measures were often impractical or difficult to implement in care home settings, what was needed to minimise transmission of infection to vulnerable residents was the right type and the right quantity of PPE/RPE for care home workers. However, this was a further area where WG inadequately protected care home staff and residents.

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

68. Guidance was issued to social care providers in a letter from Vaughan Gething on 18 March 2020, which directed that PPE should be worn by staff providing direct care to patients suspected or confirmed as having Covid-19. However, despite this guidance, some care homes in Wales received no PPE until the end of April or early May, and by 7 May 2020, only two-thirds of Welsh care homes had their PPE requirements met by the NWSSP [INQ000587254_0028, §112] – too late to prevent widespread infection and deaths.

69. A study into the introduction and spread of Covid in care homes in Norfolk[4] found that once introduced into the home, the subsequent spread of suspected Covid-19 was largely associated with inadequate access to PPE, most especially facemasks (which is likely to be similar to position facing care homes in Wales). There is ample evidence before the Inquiry that Welsh care homes did not have sufficient quantities of PPE: Helena Herklots (Older People's Commissioner for Wales) told the Inquiry there were inconsistent supplies to care homes [Module 2B, Day 2/124:5]; Chris Llewelyn (Welsh Local Government Association (WLGA)) said local authorities were unable to obtain supply of requested items through NWSSP at points throughout the pandemic, and "*demand for*

[3] Rosello et al. (01 April 2022) - Impact of non-pharmaceutical interventions on SARS-CoV-2 outbreaks in English care homes: a modelling study: https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-022-07268-8

[4] Brainard et al. (28 December 2020) - Introduction to and spread of COVID-19-like illness in care homes in Norfolk, UK: https://pmc.ncbi.nlm.nih.gov/articles/PMC7798982/

PPE was met 'on paper' however in practice the supplies could not be utilised by care professionals" [INQ000518355_0020, §§46-47]; Mr Llewelyn also referred to WLGA survey results that showed a third of local authorities said it was very difficult for care providers to access PPE, with common problems being erratic deliveries and the quality of PPE, and that "*six local authorities said orders of PPE being diverted to the NHS happened very often or fairly often*" [INQ000613908_0065, §175]; CFW wrote to the First Minister for Wales, Mark Drakeford, on 8 April 2020 on behalf of members who run care homes for the elderly stating "*our members feel they are barely receiving sufficient PPE to care appropriate for existing residents*" [INQ000499629_0002].

70. Moreover, the PPE packs prepared and distributed by NWSSP failed to provide the right type of PPE, because of a failure to recognise from the outset of the pandemic (as should have been done in accordance with a precautionary approach) that Covid-19 is transmitted via aerosols. Instead, advice from PHW to WG on 24 March 2020 stated, "*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].

71. The failure to recognise Covid as an airborne respiratory infection, which could be transmitted asymptomatically, had a significant and detrimental impact on the PPE that was advised for health and social care workers providing care to patients with Covid-19. On 16 March 2020 Vaughan Gething advised that no PPE was required if a patient or health care worker in social care did not have symptoms of Covid-19 [INQ000383574]. And within a letter to social care providers on 18 March 2020, following Mr Gething's announcement, it was confirmed that (i) PPE was for those directly caring for confirmed or suspected cases, and (ii) a higher level of PPE was "*unlikely to be needed*" in a social care setting, such equipment only being needed by those undertaking AGPs [INQ000470681].

72. However, FRSM or surgical masks are ineffective protection against an airborne respiratory infection, and FFP3 respiratory protective equipment was needed. Helen Hough was clear on this issue in her statement: "*We were not provided with FFP3 respirators, but I bought them (at great cost) on Amazon. If we thought a patient had Covid-19 (for example, because they had a temperature), we wore an FFP3 respirator instead of a surgical mask. As nurses, we knew a surgical mask would not protect us. They do not fit your face, there are gaps at the side, and they are designed to stop the wearer coughing or passing infection to a patient. They do not prevent a healthcare worker from catching infection from a patient by inhaling infectious aerosols, which is why I was asking for FFP3. I knew nurses in intensive care and critical care wards were*

receiving FFP3…" [INQ000587639_0016, §78].

73. Helen Whately also raised this concern in her oral evidence, when referencing the lower rates of infection among ICU staff who had the benefit of FFP3 respirators, and she described the inadequacy of PPE and RPE in social care settings as not "*good enough in the light of the way Covid spread*" [Day 12/80:7].

74. The need for adequate protection in care homes was raised in an email to Vaughan Gething by a Welsh Government Special Adviser on 7 April 2020, who highlighted that residential and domiciliary care staff "*clean, bathe, dress, feed, change dressings and all manner of close up activity, and the idea that district nurses will enter the same premises fully equipped (as is often observed) and they do not, continues to simply jar*" [INQ000349300_0001]. Yet no action was taken by WG. The failure to recognise that airborne transmission was a significant route of transmission, to recommend the use of RPE, and to provide this protection to care homes, undoubtedly contributed to higher levels of nosocomial infection and deaths within care home settings.

75. These inadequate PPE measures in the IPC guidance remained in place throughout the pandemic. This meant that the lack of appropriate respiratory protection, coupled with the absence of effective testing regimes, and the very nature of adult residential care - which does not allow for social distancing and requires close personal care - created a perfect storm for the virus to transmit rapidly among extremely vulnerable people. This was known from the outset by those on the frontline, like Ms Hough, but ignored by decision makers.

76. Alarmingly the most recent PHW IPC guidance for Acute Respiratory Infections in Wales (2024-25)[5] continues to recommend that social care staff use "*FRSM (type IIR) when working in respiratory care pathways and when clinically caring for suspected/confirmed COVID-19 and Flu patients*" [p.8] and only recommends FFP3 masks "*if an unacceptable risk of transmission remains following the hierarchy of controls*" [p.15]. Given the lack of adequate ventilation and isolation facilities in the majority of care homes in Wales, and the need for the provision of close personal care, the ability to apply a hierarchy of controls in these settings is extremely limited, and in these circumstances the continued recommendation of surgical masks shows how little has been learned from the tragic events of the pandemic, and makes the failures to provide appropriate PPE and RPE all the more indefensible.

Third - care home residents were deprioritised

77. Social care across the UK was described by many as a 'Cinderella' service, including by Alwyn Jones (ADSS Cymru) who said "*consideration of social care in the context of a number of decisions was always later than the NHS…it felt like the initial narrative was*

[5] https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/infection-prevention-control/ari-a-z/infection-prevention-and-control-measures-for-acute-respiratory-infections-ari-for-health-and-social-care-settings-wales-2024-version-30/

around the challenge within the NHS" [Day 15/114:3]. The focus in Wales on protecting hospitals and discharging patients to free up hospital beds resulted in a lack of consideration by NHS staff of the safety and wellbeing of elderly residents of care homes and social care staff [INQ000528094_0033, §4.44].

78. Vaughan Gething, when asked about the widely held view that adult social care is the 'Cinderella' service, responded that, "*I recognise where that comes from because it's relatively low paid but actually it's hugely important…And I think the public don't really appreciate the residential social care sector and the domiciliary care sector, because it is not as visible as the health service*" [Day 10/5:3]. However, this response totally ignored his responsibility as Minister for Health and Social Care to ensure that the decisions taken in the pandemic response, and the public statements made, reflected the importance of the social care sector and those living and working in care homes. The reality is that public briefings and policy announcements consistently focused on NHS capacity and resilience and rarely were care homes mentioned with any urgency or specificity. This absence from the public narrative mirrored their exclusion from WG decision-making. In a letter from CFW to the First Minister on 8 April 2020, they wrote: "*our members [who run care homes for the elderly] across Wales do not currently see the clarity of thinking and delivery of resources to match the stated national focus on protecting the vulnerable, when those vulnerable people are care home residents. At present, CFW is unable to reassure its members, as we have no evidence that Welsh Government - through its agencies - will provide significant resources that would be needed if care homes have (as they will if the virus enters) significant number of residents with the infection*" [INQ000499629_002].

79. Professor Banerjee in his evidence said that, "*If your internal compass faces away from people who are old, then you may be more likely to decide that individuals don't get a test, are sent back to their care homes, or sent back home, rather than afforded the extra care that can be provided in a general hospital*" [Day 15/21:21]. CBFJC submit that this tendency was displayed very clearly by WG and public bodies in Wales, which consistently disregarded the safety and individual care needs of care home residents.

80. This pattern of neglect was not incidental - it was systemic. WG's prioritisation of NHS capacity over the wellbeing of care home residents was evident early in its pandemic strategy. The decision to discharge patients from hospitals into care homes without mandatory testing or sufficient RPE, despite known risks of asymptomatic transmission and the increased vulnerability of care home residents, put those residents at direct risk of infection and death. There was a hierarchy of concern in which hospital capacity was valued more highly than minimising transmission of infection in residential care settings. As CFW put it, in a letter to Mark Drakeford on 8 April 2020, "*the current discharge approach - without tests and without sufficient full PPE - gives the appearance of 'sacrificing' the 20,000 older people in care homes in Wales, quite apart from putting staff*

at risk" [INQ000499629_0002].

81. Testing eligibility and regimes early in the pandemic further illustrate this deprioritisation. The Inquiry heard there was a "*clear prioritisation matrix*" [Day 6/121:24], which included symptomatic residents in care homes but not asymptomatic care home residents or staff. The delay in rolling out routine testing in care homes meant that outbreaks were not detected early, it became more difficult to prevent transmission and those most vulnerable to infection were placed at unnecessary risk.

82. The Equality and Human Rights Commission, which investigated WG decision making around care home residents following a referral by the Older People's Commissioner for Wales, found that "*a number of decisions in the Covid-19 response may have resulted in failures to adequately protect the right to life, including decisions about hospital discharges, admissions to care homes, prioritisation of testing and access to necessary healthcare and treatment".* Their report states that, "*Representative groups have described how the combination of decisions in the pandemic response either ignored care home residents or treated them as expendable*" [INQ000253853_0012, §32].

83. In a similar vein, there is evidence that care home residents in Wales could not always access hospitals when they needed them. Ambulance teams were reluctant to transfer residents to hospital, and almost half of Local Authorities in Wales reported that necessary transfers of residents to hospital were not undertaken. The witness statement of Helen Hough details an ambulance team refusing to take a resident to hospital because they had a temperature, and the ambulance team's instructions that they were not supposed to transport anyone from a care home [INQ000587639_0006-7]. Ms Hough recounted the conversation with the ambulance crew in her oral evidence, "*they said to me,* "*The hospital aren't going to be very pleased with this*", *and I went outside the building and I did say to the ambulancemen,* "*It's not up to you to play God here. You're just taking in poorly patients into hospital. You don't get to decide…who lives or dies in this home*" [Day 2/131:5-10].

84. The blanket application of DNACPR forms on the medical records of care home residents - without discussion with them or their families - was a particularly egregious example of systemic disregard. DNACPR was used as a proxy for 'Do Not Treat', resulting in automatic non-admittance to hospitals and patients not receiving the care and treatment they needed, which may have prevented death. One Welsh care home manager gave the following harrowing account of the circumstances of the death of a resident who did not receive adequate treatment and care: "*For whatever reason, perhaps because they weren't confirmed as Covid-19, or perhaps because sufferers can take a turn for the worst and death can come on quite quickly, no palliative care package was put in place by the GP and controlled drugs were not issued to try to ease them with any possible suffering...[The patient] unfortunately passed away within 24 hours and the manner of their passing has affected some of the staff quite badly with [the patient] struggling to*

breathe and in effect slowly suffocating to death. Nobody should have to die like this. I get the fact that these are extraordinary times and we are in the middle of a crisis, the like of which none of us have seen before. However, there appears to be [a] race by GP's to place DNACPR on lots of individuals, which would mean automatic non-admittance to hospitals and possibly many more examples of these horrific deaths, and with no apparent thought as to how if people suddenly take a turn for the worst how they may be helped to pass in a more comfortable and humane way…Care homes do not have a general supply of stock medication supplies for end of life care, nor access to oxygen. How confident are we that residents and their families understand the implications of a DNACPR?" [INQ000500163].

85. In particular, the lack of oxygen, palliative care and medication to ease the suffering of those dying from Covid-19 in care homes was cruel and inexcusable. CIW raised concerns directly with WG from March and April 2020 about the need to support care homes providing end-of-life care to patients with Covid-19: "*family members will be distraught if they are aware of these details. In these extraordinary conditions it is imperative that people who die in care homes with Covid 19 are treated with dignity, compassion and can be made as comfortable as possible*" [INQ000500163].
86. The directive for GPs to shift to remote consultations where possible in order to reduce the risk of infection meant that interactions between GPs and care home residents were often conducted virtually. Combined with the suspension of non-Covid healthcare services for long periods of time, this shift meant that for many residents, regular check-ups, diagnostics and timely medical interventions were delayed or missed entirely. This had a particular impact on care home residents due to the prevalence of chronic conditions and complex health needs amongst this population. It is CBFJC's belief that this contributed to a significant decline of care home residents through worsening health conditions, undiagnosed illnesses, and, in some cases, preventable deaths.
87. The emotional toll and ethical strain on care home staff were immense, as they were left to manage pain and suffering that could have been alleviated with proper intervention. Ms Hough felt that nobody was speaking up for her patients [Day 2/131:12], and she wrote to WG officials on 4 May 2020, as a "*very distraught tired nurse feeling helpless*" setting out the desperate position facing care homes residents and the disgraceful disparity between their treatment and that of NHS patients: "*We have no oxygen on site…I have tried to get GP's to prescribe it but they give us end of life drugs instead. Relatives would be horrified if they could see how poor their relations are being treated in care homes, but because there is no access to visitors they are not witnessing this…As a patient's oxygen saturation level drops with this disease they are gasping for breath, and we cannot give any oxygen relief at all, and as this is the only treatment for COVID19 this is disgraceful, it is 'on tap' at a hospital so patients in hospital will already [be] receiving better care than what we can*

give at a care home" [INQ000598472].

88. The stark reality is that most Welsh care homes were wholly ill-equipped to look after residents who were very unwell or dying. The Inquiry heard from Gillian Baranski (CIW) that the majority of Welsh care homes did not provide nursing care: "*790 of our care homes [out of 1,053] didn't have nursing and therefore they didn't have access to end-of-life medication and to oxygen*" [Day 5/191:1]. This structural limitation was known to WG and should have informed urgent resource allocation. Instead, WLGA survey results show that 59% of local authorities in Wales reported that residents were not receiving adequate medical treatment and 47% reported that necessary transfers to hospital were not undertaken [INQ000613908_0074-0075, §§193-194]. There is no evidence that these issues were a priority for WG.
89. Routine inspections in care homes by CIW ceased in March 2020, which resulted in a lack of monitoring and understanding of what was happening in those homes. Helen Hough's evidence was that, "*there was no comprehension on the part of the local authority, the [Local Health Board] or CIW as to what we were dealing with on a day to day basis. We were so busy, all the time. And when we started to lose patients, it was devastating for all of us*" [INQ000587639_0013, §62].
90. CBFJC recognise that an initial suspension of inspections in March 2020 was reasonable, but given the desperate and frightening circumstances that care home residents and staff were facing, the suspension of routine inspections throughout the pandemic was inappropriate and CBJFC agree with the evidence of Dr Allen (British Association of Social Workers) that the need for monitoring and inspection was heightened rather than reduced [Day 4/48:21-22]. Gillian Baranski told the Inquiry that by June 2020, CIW inspectors had available sufficient PPE and testing to enable more inspections [Day 5/160:11]. However, routine inspections were not reintroduced in Wales until 4 August 2021 and Wales recorded the lowest number of inspections across all UK nations during the financial year 2020-2021 - just 20% of the number of inspections undertaken in the year 2019-2020 [INQ000587847].
91. Data challenges were another significant issue affecting the care sector and Chris Llewelyn (WLGA) stated, at §124 of his statement, that "*During the pandemic there were several data-related challenges that impacted decision-making, service delivery and resource allocation. This included data availability and collection issues, where there was a lack of real-time data on care home residents, staff absences, and infection rates which made it difficult to respond quickly to outbreaks*" [INQ000613908_0050]. While care homes were required to notify CIW of suspected or confirmed Covid-19 in staff or patients from 12 March 2020 [INQ000569773_0062, §189], testing capacity, patients not exhibiting 'common' symptoms, and asymptomatic infection meant that recorded rates of infection and deaths from Covid were inevitably inaccurate. There were also known difficulties reconciling data held by CIW on the numbers of cases and outbreaks in care homes with

PHW data on notifications of infectious diseases [INQ000569773_0012, §39] [INQ000587702_0037-38, §§123-127]. There was no apparent priority in addressing these issues and Professor Bolton's rapid review for care homes in Wales, published in September 2020, highlighted the challenge of "*a large number of public bodies all looking to play their role in the system but sometimes 'tripping over' each other to collect data and to understand what was happening in specific care homes without obvious benefits to the care homes themselves*" [INQ000253708_0009]. This inevitably led to a lack of accountability for the protection of those in care homes, which must be addressed.

92. Older people in Wales contributed more than any other group to the fabric of Welsh society, and yet their needs and rights were overlooked and dismissed time and again. Despite knowing that older people in residential care and nursing homes were the most vulnerable to Covid-19 infection, they were consistently deprioritised in the decisions taken by WG and public bodies. Simply because of age or cognitive impairment, they were written off as deserving of care, protection or adequate treatment. CBFJC agree with the closing remarks from Professor Vic Rayner, that "*we need those decision makers to think about social care first. It's not Cinderella. It's not the handmaiden of the NHS. It's a vital public service that's the backbone of communities. And we forgot that then and we must never do that again*" [Day 4/119:14].

Fourth - failure to prepare for the second wave and to learn lessons

93. The second wave of the pandemic saw further huge loss of life in Welsh care homes. ONS data analysing deaths across England and Wales shows that Wales had the highest proportion of Covid related deaths of care home residents in Wave 2 - at 28.8% [INQ000509882_0006].
94. It was well known that there would be a second wave of Covid-19 with the potential to be more severe than the first. The current Chief Scientific Adviser to the UK Government, Professor Dame Angela McLean, described in her witness statement to Module 2 that the September and October 2020 period was "*the worst moment of the pandemic*" [INQ000309529_0046], because, "*we could see what was coming and could not understand why the government did not act upon the science advice by introducing effective interventions*" [NQ000309529_0044], and "*We could see infection rates rising. We knew that a large portion of the population had still not been infected so were still susceptible. It was therefore inevitable that the epidemic would grow larger"* [INQ000309529_0045].
95. The monthly reporting to CIW [INQ000198645 tab 9] shows how the numbers of suspected and confirmed Covid-19 deaths in care homes in Wales fell to single figures in July and August. This 2020 summer lull provided an opportunity to take steps to prevent further significant loss of life. However, not only was this opportunity squandered, but decisions were taken that placed care home residents at increased risk, resulting in further devastating loss of life with 1,138 suspected and confirmed Covid-19 deaths in Welsh

care homes in the second wave (October 2020 to February 2021) and a peak of 460 deaths in January 2021.

96. On 25 November 2020 WG decided to intentionally delay the vaccination of care home residents, contrary to the explicit recommendation of the Joint Committee on Vaccines and Immunisation (JCVI) [INQ000493687_0023, §95]. The reason that care home residents were the first JCVI priority cohort for vaccination was because of their extreme vulnerability and because vaccination had such pronounced benefit, as explained by Professor Wei Shen Lim in his evidence [Module 4/Day 8:89/7-90/6]: "*the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age care home, we would protect one life. The same number needed to vaccinate to prevent one person from dying in a 65-year old cohort was 1,000, and of the number needed to vaccinate -- to prevent one life -- save one life in the 50-plus cohort is 8,000. So by the time we get to children and young people who have no underlying health conditions, then the number needed to vaccinate to prevent one adverse outcome -- clinical outcome, not safety outcome -- is in the many tens of thousands*".
97. The requirement for ultra-low freezer capacity for the Pfizer vaccine was known from at least 25 August 2020 [INQ000501330_0018 §67] and the failure to procure the necessary freezer storage and develop a delivery plan for care homes in the four months to December, given the known risks to life, is inexcusable. All UK nations faced this challenge, but the response of WG was by far the least effective. Vaccinations in Wales commenced on 8 December. However, by 26 January 2021 only around 67% of care home residents had received their first dose [INQ000508504]. By 16 February, at the tail end of Wave 2, this number had risen to just 82% [INQ000410143].
98. In contrast, Scotland reached this level over a month earlier on 12 January 2021 [INQ000376337] and Northern Ireland delivered vaccinations to care home residents on 8 December 2020, the first day of the programme, and by 26 February 2021, all residents and staff in their care homes had been offered a first and second dose [Day 1/166:14-24]. The WG's departure from JCVI advice was discussed in a Cabinet Office meeting on 12 January 2021 [INQ000088889] when it was noted that Wales had taken a different approach to other nations by prioritising NHS staff for the Pfizer vaccine.
99. This poor performance was accompanied by the usual spin and false statements that CBFJC has come to expect of WG. In the witness statement of Mark Drakeford to Module 4, it is stated, "*On 18 January 2021, during a BBC Radio 4's Today programme I was asked about the vaccine roll out in Wales and the suggestion that Wales had vaccinated fewer proportion to its population than other nations of the UK. I explained that there was a very marginal difference in the vaccination statistics but in any event, I explained that the supplies of the Pfizer vaccine had to last until the beginning of February*

and would not be used all at once. I explained that it would be logistically damaging to use the vaccine all in the first week and the sensible thing to do was to vaccinate over the period that we had to vaccinate, so that the system could absorb it. At no time was the Pfizer vaccine withheld. All Health Boards were received doses of Pfizer which were successfully deployed in a manner to minimise wastage, which at that time was less than 1%. I committed to vaccinating all four priority groups by the middle of February and this was achieved" [INQ000474420_0030]. This statement is incorrect in two material respects: first, the statement, "*at no time was the Pfizer vaccine withheld*" is not correct, and vaccines were deliberately withheld from care home residents by a decision of the Minister for Health and Social Care, Vaughan Gething, on 25 November 2020; second, the statement, "*I committed to vaccinating all four priority groups by the middle of February and this was achieved*" is also not correct, with only 82% of care home residents being vaccinated by 16 February 2021.

100. Given that the case fatality rate among infected unvaccinated elderly care home residents was one in three, and that vaccine effectiveness for this group against death from Covid-19 was established at between 64% and 96% for doses one and two, rising to 97.5% after dose three [INQ000544935][6], this represents yet another failure by WG to implement an essential safety measure until it was too late to avoid mass fatalities, and shows how little they learned from Wave 1.

101. Another decision that placed care home residents at increased risk was to discharge hospital patients with low level positive tests to care homes from 15 December 2020. The risk was described as low; however, there remained uncertainty. And there had been concerns about the possibility of such a reversal from as early as 3 July 2020, as described at §102 of the witness statement of Claire Sutton of the Royal College of Nursing: "*Helen Whyley wrote to Dr Andrew Goodall, Director General Health and Social Services and Chief Executive NHS Wales, after being given the opportunity to comment on the document NHS Wales Covid-19 Operating Framework - Quarter 2 (20/21) [CS/013 - INQ000525175]. The RCN was pleased that there was still a focus on older people in care homes and that their needs were being met. We felt, however, that we were missing an assurance that any older person being admitted to a care home or returning from hospital would have tested negative for Covid-19 prior to their transition.*" [INQ000587657_0027].

102. The fact that the WG was prepared to take risks with the lives of care home residents by discharging positive testing patients into care homes at a time when deaths in care homes were rising rapidly, having already suspended vaccinations, and knowing the devastating impact of infection once it entered a care home, disproves the claims of the WG

[6] Duration of vaccine effectiveness against SARS-CoV-2 infection, hospitalisation, and death in residents and staff of long-term care facilities in England (VIVALDI): a prospective cohort study' published in the Lancet in July 2022

that the most vulnerable in Wales were at the heart of their decision making.

103. CBFJC were also promised a care home investigation by Mark Drakeford during a face-to-face meeting with him at WG buildings in August 2022. He agreed that "just because it is difficult, it doesn't mean it shouldn't happen". However, no investigation was commissioned, and instead a 13-page good practice guide, 'Undertaking Factual Reviews for Residents Who Acquired COVID-19 Within the Care Home Sector'[7] was issued to care home providers in October 2023. Not only does this guidance place the onus of investigation on care home providers, but there is also no duty or requirement to conduct an investigation, meaning few, if any, will have been performed, and with no means of considering the national picture, nor the role and actions of the WG and other public bodies. When this guidance was published, CBFJC immediately wrote to WG on 26 October 2023 to complain that the First Minister had agreed to a Welsh care home investigation, and that the guidance failed to deliver on this agreement. Further, that what was required was an investigation in Wales to determine why care homes were not prepared for an airborne and asymptomatic virus, why they had so many cluster outbreaks, why PPE, oxygen and testing was unavailable, the impact of staff movement between different care home premises, and a definite account of the numbers and causes of death of those who died over the pandemic while in care homes, particularly in the absence of any inquests. The failure of WG to hold such an investigation is typical of WG in making false promises, avoiding scrutiny of their actions, and failing to seek to learn from their mistakes.

Conclusion

104. The anger felt by bereaved families in Wales is not just rooted in the loss of their loved ones, but in the neglect and indignity that they suffered, in the WG's refusal to accept their mistakes, and in the ineffectiveness of organisations tasked to protect care home residents. The WG needs to take responsibility for what went wrong so that there can be learning and improvement and so that families can begin to move on.

105. Despite challenge from organisations such as CIW and the OPCW, they were unable to effect meaningful change during the pandemic. CBFJC therefore seek a recommendation that will provide genuine independent scrutiny of the care sector in Wales allied with powers to hold those responsible for the provision of care accountable.

106. CBFJC conclude this closing statement with the words of Helen Hough, in her email to the Welsh Government on 4 May 2020, in which she stated "*I do hope, when this is over, this is all thoroughly investigated, because I and many other Managers will be stating what a diabolical shambles this is in Wales, and possibly causing many unnecessary deaths…*" [INQ000598472].

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[7] https://www.gov.wales/sites/default/files/publications/2023-10/undertaking-factual-reviews-for-residents-who-acquired-covid-19-within-the-care-home-sector.pdf