UK COVID 19 INQUIRY

MODULE 10:

IMPACT ON SOCIETY

WRITTEN OPENING STATEMENT

ON BEHALF OF THE COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU (CBFJC)

Introduction

1. The members of CBFJC came together to support each other, get answers, give their loved ones who died a voice, and to effect meaningful change. The group is proud to represent the Covid bereaved in Wales at the Inquiry's proceedings, and it is grateful to the Inquiry for enabling its participation.

2. The impact of Covid-19 on the members of the CBFJC has been heavy and prolonged, and while bereavement is a highly individual and personal matter, with each member processing and responding to the loss of their loved one in a different way, there are many common themes to their bereavement, addressed in turn within this statement, as follows:

    a. Lack of bereavement support.
    b. Visiting and funeral restrictions.
    c. Inadequate information about the circumstances of death, including inadequate complaints, inquests and investigations processes.
    d. The deprioritisation of older people
    e. The lack of dignity in death
    f. Photography of the sick, dying, and dead in hospitals.
    g. Inadequate memorial and remembrance
    h. Lack of accountability
    i. Failure to learn lessons
    j. Ongoing impacts on wellbeing and mental health

Lack of bereavement support

3. The four countries of the UK experienced extreme levels of loss of life during the pandemic (over 200,000 people and an excess death rate of approximately 10%),

many of which occurred in lonely isolated circumstances and without the ability to properly grieve because of restricted funerals. In these circumstances, the provision of bereavement support should have been seen as essential but instead there was an almost total absence of practical and psychological support in Wales.

4. In the immediate aftermath of the death of a loved one, interactions with healthcare bodies were often impersonal and business like, with bereaved family members sent home with missing or the wrong possessions (one family were unable to retrieve their father's wedding ring), clothing that was soiled, and with frightening instructions that it may be infected, which led many families to destroy their loved one's property. There were even horrific instances of the bodies of family members becoming lost within morgues for prolonged periods of weeks, such was the state of chaos.

5. Members were forced to navigate the complexities of registering their loved one's death with all the restrictions in place, without any guidance or support.

6. The lack of any proper bereavement support left bereaved families feeling alone and vulnerable, at a time when it was not possible to seek support and comfort from family and friends in the usual way (including families with relatives who lived abroad who were unable to support each other because of the 14 day quarantine period).

7. When the possibility of counselling through the NHS was discussed, families were often told that they were not ready (as they were experiencing grief) and that they should seek counselling elsewhere, for example through charities.

8. The National Bereavement Framework, set up in 2019, proved to be completely ineffective and CBFJC is not aware of any Welsh Health Board that implemented bereavement support processes in the first 18 months of the pandemic (not one of the Health Board websites was updated with Covid-specific bereavement information).

9. CBFJC successfully lobbied for two years' funding for a bereavement lead in each Health Board, working with the National Bereavement Steering Group and the Bereavement Lead in Welsh Government. This was included in the Welsh Government's national framework for the delivery of bereavement care, published in October 2021, which stated that commissioners must ensure bereavement services are properly coordinated to provide a consistent level of service to bereaved people.

Permanent funding was later agreed. However, some Boards still do not have a bereavement lead in post.

10. The group also advocated for training for bereavement leads so that they are better equipped to deal with the particular circumstances and different dynamic involved when someone dies from a hospital acquired infection. Similarly, this is yet to be put in place.

Visiting and funeral restrictions

11. Visting restrictions meant that hospital in-patients and residents of care homes were left isolated and alone, which, particularly for the elderly and vulnerable, led to worsening mental and physical health, and was a contributory factor in many deaths over the period of the pandemic.

12. The inability to visit, support and comfort loved ones has left many of the bereaved haunted by feelings of guilt that they did not try hard enough to visit and/or care for a family member at home. And, these feelings are exacerbated at having subsequently learned just how dangerous hospitals and care homes were during the pandemic.

13. Not being able to check and ensure that loved ones were being cared for properly caused families tremendous worry and anxiety, and also compounded their feelings of guilt.

14. Given the isolation of so many patients and residents the existence within hospital and care home settings of a patient/resident advocate would have been welcomed. Many patients were wholly reliant on their care providers to facilitate family communication (and these health and social care professionals were incredibly busy and not in a position to perform this role). One group member recalls that their father, who would himself sadly go on to die from Covid-19, witnessed a fellow patient who was clearly in the end stages of life in the bed opposite him on a 6 bed ward. The man was elderly and alone and the group member's father tried his best to contact their family by phone during the night (in the absence of the availability of hospital staff). When he was unable to do so he simply sat with the dying man himself, which is all that he was able to do.

15. The seemingly arbitrary nature of the restrictions for both visiting and funeral attendance have also caused anger and frustration. Hospital patients who were mobile enough were able to meet with relatives in hospital entrances/concourses and outside the hospital buildings, following which they would return to their wards. Whereas patients who were not well enough to meet in this way could not receive visitors. Permitting one form of patient/visitor social interaction while preventing another did not make sense to those families who were prevented from seeing their loved ones. One group member commented about these arrangements that it was, "survival of the fittest".

16. Similarly, there was often day to day variation in the required levels of PPE and other IPC (with varying degrees of compliance), and the fact that the rules did not appear to be universally applied and complied with has compounded the feelings of regret and guilt of those families who were not able to see their loved ones before they died. And on the rare occasions when family visits were permitted, families often found it ironic that they were perceived as the danger, given the poor standards of IPC (particularly ventilation), and PPE, in place.

17. Funeral restrictions were inhumane and a national disgrace. They have left huge numbers of people permanently scarred and almost every family bereaved over the pandemic speaks of the trauma of this experience and how there was an inability to properly honour and mark the passing of their loved one.

18. The family of one man who died alone in a care home were not permitted to visit the chapel of rest or see the coffin until the hearse arrived at their home, and after seeing the coffin for the first time in the street his wife of 56 years had to be physically supported to prevent her from collapsing with grief.

19. These experiences also include the separation of families and friends during and at funerals, with difficult decisions having to be made about who was able to attend and travel together, and of curtailed and disrespectful services.

20. The inability to perform religious and cultural rituals surrounding death has had a profound impact. These rituals offer both comfort to the bereaved and gratitude for the life lost allowing the bereaved to process loss in a familiar way. One group member comments, "The grief is prolonged and somehow made larger. I didn't hug another person from when Dad was diagnosed until restrictions were lifted 6 months later.

Arranging his funeral alone, without the comfort of a hand to hold, felt completely unnatural and still makes me cry."

21. These restrictions (both on the ability to support loved ones through their illness and on remembering and respecting them in death through funerals and other rituals) made it all the more important for there to have been proper bereavement support in place – but instead of recognising this need and increasing provision, it was reduced.

Inadequate information about the circumstances of death, including inadequate complaints, inquests and investigations processes

22. The unprecedented loss of life and the lonely and isolated circumstances in which many people died meant that there was more need than ever to explain the circumstances in which death occurred to bereaved families. However, just as with bereavement services and funerals, when this need was at its greatest, the existing systems and services in place were found badly wanting, leaving many families completely in the dark about what happened, and feeling powerless.

23. Complaints processes are complex, lengthy, and re-traumatising and the tragedy is that in most cases they were completely avoidable had there been effective communication with bereaved families at an earlier stage.

24. Again, the inability of families to visit loved ones and to engage with the treating healthcare professionals, meant that more than ever there was a need for clear and timely explanations about the circumstances in which their loved ones died.

25. The absence of this information created a vacuum which desperate families resorted to fill with their own narratives, out of necessity. This has led in some circumstances to false narratives taking hold which can be hard to shift. A bereaved family member has commented, "in the absence of any facts our imaginations reached for the darkest and most frightening possibilities and that is what became 'truth' and what we live with every day."

26. Many families simply gave up trying to find out what really happened and have had to learn to live with the fact that they will never know, constantly wondering, "what if".

27. Many complaints originated in simple requests for information, which when they were either unanswered or responded to inadequately, led to escalation.

28. Families experienced huge delays in responses to complaints, and many responses were incomplete, inconsistent, and inaccurate. For example, one family received seven different responses, each revealing new, horrific information (such as the failure to provide oxygen to their loved one for 40 minutes), prompting fresh questions which in turn went unanswered. It was also not uncommon for families to learn of distressing information such as the existence DNACPR notices and Treatment Escalation Plans, of which they had not been previously made aware.

29. Many responses were in a template/pro forma style, drafted defensively, and with an emphasis on seeking to avoid liability rather than to provide bereaved families with answers. They would also often contain hollow meaningless apologies.

30. It is bewildering to bereaved families that the importance of providing clear information and explanations about the circumstances of death, in a form and manner that is understandable to ordinary people, has not been recognised given that so many deaths occurred unexpectedly and while people were isolated from their families.

31. The inadequacy of the complaints process, including a lack of candour and reflection. has resulted in re-traumatisation and has prolonged and exacerbated the impact of Covid 19 on the bereaved in Wales.

32. Members also found the process for obtaining hospital and care home notes very challenging, and when they were provided they were often not in any chronological order, often with significant gaps, and with signs that they had been created well after the event. Bereaved families understand the pressures that healthcare professionals were under and they are grateful for the incredible effort and sacrifices that healthcare professionals made to care for their loved ones. They are also understanding that mistakes happened and that, for example, there wasn't always time to create medical records to the expected standard outside of a pandemic. They simply want to be told the truth about what happened without which it is extremely difficult to achieve closure.

33. There was a compelling need for inquests, for example into the circumstances of cluster outbreaks and deaths in hospitals due to inadequate infection prevention and

control, and where 50% of care home residents died, potentially caused by the practice of transferring hospital patients without testing. But this has not happened.

34. Inquests were held for healthcare professionals who were infected while at work, and this is entirely appropriate. However, they should also have been held for patients who died following a hospital acquired infection, and for residents of care homes who died from a nosocomial infection.

35. Inquests would have provided answers, enabled lessons to be learned, and helped bereaved families come to terms with the unexpected death of a loved one. Bereaved families believe that they have a right to know the circumstances in which their loved one's died.

36. The lack and/or tokenistic nature of the investigations leaves a burning sense of injustice reminiscent of other traumatic events such as Hillsborough, and the infected blood scandal. This sense of injustice is a feature of Covid-19 bereavement and the members of CBFJC are determined to see it put right.

37. The pandemic created a perfect storm of conditions that has led to prolonged and exacerbated bereavement – no contact with dying relatives and friends, no bereavement support, no funerals, no information about what happened (and on occasion misinformation), no investigations into the circumstances of unexpected and multiple deaths, and no learning and improvement.

38. Bereaved families campaigned extensively for a national investigation into deaths from nosocomial infection, and the Welsh Government announced a two year investigation in January 2022 to, "…not only investigate into every case of hospital-acquired COVID-19 infection, but learn why it happened so we can do everything in our powers to prevent it from happening again". However, when the investigation reported, the absence of specific findings about the circumstances in which so many people died from hospital acquired infection shocked bereaved families in Wales.

39. Similarly, bereaved families in Wales were promised a care home investigation by the Welsh Government in 2022, but nothing has been delivered.

40. These failures to match rhetoric with action have exacerbated and prolonged grief and bereavement in Wales.

41. Many families talk about their sense of dread when a loved one was admitted to hospital for necessary treatment (unconnected to Covid-19) and the feeling of inevitability that they would become infected and die, which tragically happened in so many cases.

42. One member recalls how afraid they were that the virus would be introduced into her father's care home and recalls a member of staff telling her that, "it felt as though we were just waiting for the inevitable".

43. The urgent need for a thorough investigation into every death from nosocomial infection (in hospitals and care homes) is blindingly obvious when the circumstances of individual cases are examined, such as the following harrowing experiences:

    a. A couple (John and Mary) who had been together for over 50 years. Mary needed hospital treatment for a few days but they were assured that she would be kept on a ward with no Covid-19 patients. Shortly after Mary returned home she became unwell with Covid-19 and had to be re-admitted upon which the hospital informed the family that there had in fact been an infected person in the bed next to Mary's during her first admission. John also became very ill within a few days and after calling the paramedics for help the next thing he remembers is waking up next to Mary in hospital. Mary was extremely ill and John was told that she was too ill even for intensive care. Mary died two days later while in a bed next to John, and he discharged himself the same day because he could not bear to stay in the same place that Mary had died. He comments, "…it was the hospital of all places that gave it to Mary…when they took Mary's life they took mine too".
    b. Ann, who was clinically vulnerable was admitted to hospital following an accident at home in January 2021. Her family were assured that she would not be accommodated with Covid-19 patients. Ann became infected with Covid-19 while in hospital and because of her underlying vulnerabilities it was decided that she could not be treated and she steadily deteriorated and died over a four day period while in hospital. Ann's family made a complaint about the care and treatment that she received while in hospital and it was only through this complaint process that the family discovered that Ann had in fact been on a ward over a period of approximately two weeks that had experienced two outbreaks of Covid-19. Despite Ann's vulnerabilities she was not transferred to

another location over this period and being unable to visit and in the absence of being told, the family would never have known but for making a complaint about a separate issue.

c. Rosalind, who was admitted to hospital following a fall at home on 4 March 2020. While in hospital she tested positive for Covid-19 on 24 March 2020. Despite this, and without a negative test, Rosalind was identified as suitable for transfer to a care home on 31 March 2020. In the event, the transfer to the care home did not occur until 6 April 2020. However, there was no negative test prior to transfer, and a physiotherapist recorded their clear objections to the transfer within Rosalind's medical notes on the day of transfer because in their professional opinion she was not medically fit for transfer. Despite having a Covid-19 infection and her frail condition, Rosalind was transferred to a care home that was wholly unsuited to care for someone so unwell. Rosalind steadily deteriorated while at the care home until her death on 17 April 2020. Her family were unable to visit during this period and her daughter believes that she witnessed her mother die through the window while she stood outside (a vigil that she had maintained morning through evening the whole time her mother was in the care home). The death certificate recorded "Coronavirus Infection" as the primary cause of death and the family is not aware of any investigation into these circumstances as part of the national nosocomial investigation.

d. Phil, who was receiving treatment for cancer in connection with which he required admission to hospital in early January 2021. Phil's family were extremely worried about the risks of Covid-19 infection in hospitals at this time and sought a vaccination for Phil prior to his admission. However, this could not be provided despite his vulnerabilities as a cancer patient. While he was in hospital his family asked permission to provide him with a portable electronic HEPA filter to guard against the risks of airborne infection, but the hospital refused to allow this. Phil's family received the news that they had been dreading on 21 January 2021 that he had been infected with Covid-19, and he died from this infection in very difficult and distressing circumstances on 26 January 2021 without his family being able to visit him. The week after he died a letter was received inviting him for his Covid-19 vaccination. Phil's death certificate states that the primary cause of death was Covid-19. However, the national nosocomial investigation response letter disputed this and claimed that he died from a blood infection, which the family were horrified to receive, and strongly dispute. The coroner subsequently confirmed that there has been no

application by the Health Board to seek to amend the cause of death, which and as already mentioned, clearly states that the primary cause of death was Covid-19.

e. Alwyn was a resident of a care home in Wales that experienced a Covid-19 outbreak in April and May 2020, at which 26 out of a total of 52 residents (50%) lost their lives to Covid-19. Alwyn (and many other residents) became infected in early May following the transfer of infected and untested hospital patients to the care home. Until the pandemic struck, Alwyn was visited every day by a member of his family, and the fact that he died without his family by his side, having become isolated because of the restrictions on visiting, has been deeply painful for the family. Such was the atmosphere of fear at this time that the family burnt their clothes following a brief visit to the care home, and at Alwyn's funeral, anti-bacterial sprays and wipes were provided to the small number of people allowed to attend. It is vitally important that the circumstances in which the transfer of untested hospital patients into extremely vulnerable care home communities was allowed and directed, with such tragic and devastating consequences, is properly investigated.

f. A married couple of 59 years, Diane and Colwyn. Colwyn was clinically vulnerable and suffered from vascular dementia and had undergone heart surgery in recent years. He required hospital treatment for sepsis on 9 December 2020 on which date he was admitted and tested for Covid-19, with a negative result. Colwyn was transferred to a second hospital two days following his admission where Diane witnessed a patient returning to their ward who was warned by security staff for potentially endangering other patients through their movements, which caused Diane concern at the risk of infection being introduced onto the wards and at the levels of infection prevention and control in place. Diane's concerns were compounded when Colwyn was discharged in a very fragile condition on 18 December 2020 wearing someone else's coat with chewed sweets in the pockets, a washbag that was not his that contained a urine soaked sock, and a patient property bag that contained a job application in the name of a member of hospital staff! Colwyn developed Covid-19 symptoms on 20 December 2020 and the GP diagnosed hospital acquired pneumonia and identified that Colwyn was seriously dehydrated (as a result of his hospital admission). Both Colwyn and Diane tested positive for Covid-19 on 24 December 2020, and consideration was given to re-admitting Colwyn to hospital because of how ill he was. However, Colwyn was terrified to return to hospital and Diane did all she could to care for him at home until he died a

week later on new year's day. Diane suffered debilitating Long Covid symptoms and has scarring on her lungs, and while she did everything she could for Colwyn, she continues to experience guilt because at the moment Colwyn died she was unable to be by his side because she herself was so exhausted from the effects of her Covid-19 infection. The GP referred the case to the coroner because of concerns at Colwyn's condition on discharge and the circumstances of his infection, but no inquest was held. Colwyn had expressed a wish that his brain and spinal cord be donated to research into dementia. However, when Diane attempted to honour his wishes, she was rebuffed in upsetting and unempathetic circumstances because of the Covid-19 infection. Diane was not able to see Colwyn again after he was taken from the house and although 18 people were able to attend the funeral, many more were kept away. Diane subsequently discovered that there had been a Covid-19 outbreak on Colwyn's hospital ward. Despite this outbreak, and the fact of the negative test on admission, and that Colwyn's symptoms developed just two days after discharge, the hospital continue to deny that the infection was nosocomial.

g. Eirwyn, who was admitted to hospital in November 2020 for an essential surgical procedure. The surgery went well and Eirwyn was making a good recovery. However, he had a condition of diabetes and was clinically vulnerable which was concerning to his family who wanted him home at the earliest opportunity. Eirwyn was assessed as medically fit for discharge on 4 December 2020, but this did not happen straight away because of the absence of medical equipment, including a wheelchair. After waiting a number of days for a wheelchair to be provided his wife became exasperated and personally drove to a NHS warehouse (an hour's drive away) to collect the wheelchair and deliver it to the hospital. Eirwyn's discharge was then further postponed because of delays with the provision of occupational therapy. Eirwyn had commented before being admitted to hospital, "knowing my luck I'll get Covid". Tragically, this came to pass, because before he could be discharged Eirwyn started to exhibit symptoms of Covid-19 on 13 December, and a positive test was confirmed on 17 December 2020. Despite continuing to suffer from Covid-19 Eirwyn was discharged on 25 December 2020, but his condition deteriorated while at home to such an extent that he had to be readmitted to hospital on 1 January 2021. He never recovered and died from Covid-19 in hospital on 8 January 2021. That Eirwyn died because he could not be discharged from hospital for something as simple as the provision of a wheelchair that was stored in a warehouse just one hour's drive away, haunts his wife and family.

The family subsequently discovered (although they were not told at the time) that the hospital experienced a Covid-19 outbreak between 2 December and 30 December 2020 during which 25 patients and 25 members of staff were infected with Covid-19. As a clinically vulnerable patient, more should have been done to ensure that Eirwyn was not exposed to these risks given that he was fit to be discharged from 4 December (and was not infected until over a week later). Eirwyn's wife was not able to be with him when he died, and she was refused an opportunity to see him before the funeral (he was placed in a body bag and in turn within a sealed coffin). Eirwyn's wife comments that, "for a long time it felt like he had been kidnapped by the NHS". She has been traumatised by the circumstances in which Eirwyn died and from the inability to mourn and grieve properly (the usual funeral restrictions applied), and she continues to receive counselling to help her cope. Eirwyn's wife wants to see change so that others don't have to endure a similar experience, but comments that nothing has changed for the better.

The deprioritisation of older people

44. CBFJC acknowledges that this issue was addressed in Module 6 (care homes). However, the group wishes to briefly raise it again in the context of bereavement.

45. The elderly were most seriously impacted by Covid-19, yet despite having made the biggest contribution to the fabric our society, in their time of need they were abandoned and deprioritised.

46. The pandemic caused and allowed thinking, even among healthcare professionals, that elderly people were dispensable. This collective failure is a national disgrace and it should never be allowed to happen again.

The lack of dignity in death

47. Closely linked to the deprioritisation of elderly people (but not exclusive to this group) is the lack of dignity in death.

48. For bereaved families to know that their loved ones died while lonely, scared and confused, without adequate and appropriate treatment, without adequate pain relief

and hydration, and with decisions taken, such as treatment plans and DNACPR notices in place, without their consent, only compounds their grief.

49. Similarly, the way the bodies of loved ones were treated after death, the handling of their property, and the cursory nature of the funeral rites permitted.

Photography of the sick, dying and dead in hospitals

50. Some hospitals in Wales authorised photography of patients, including the dead and dying. The experiences of grief and bereavement of many group members have been significantly prolonged by the discovery that photographs of dead and dying Covid-19 patients were taken within the hospitals where their loved ones died. Many thousands of photographs were taken, with these images published widely including on Twitter, Instagram, within books, websites, YouTube videos, media articles, and even on sale in art galleries.

51. They show seriously ill patients who are semi-naked, intubated, and turned and prone. There are also images of body bags, personal belongings (including false teeth), and of bloodied floors. Some patients are clearly identifiable.

52. One member's loved one was filmed by a news channel whilst he was being treated with CPAP oxygen – his family saw this on TV with no discussion or prior warning given.

53. Within another family there is uncertainty whether a published image shows their dying husband and father, with some family members thinking it does and others not, which has caused unnecessary trauma.

54. A tweet sent by a member of hospital staff featured a photograph of a body in a morgue with the words, “bad day at the office”. One family members comments that this was from the hospital around the time that their dad died and that they will never know whether this was his body.

55. CBFJC doubts that such serious and invasive breaches of patient confidentiality and privacy can be justified by the public interest in recording the pandemic. The group does not expect the Inquiry to determine any individual breaches of data protection and confidentiality. However, as there is such widespread public concern at this

practice, and given the deep distress that has been caused to so many families in Wales, the group asks that the Inquiry takes it into account.

56. When challenged about the photography, the Health Board in question was typically defensive, evasive and unhelpful, citing technical aspects of data protection. Their failure to instinctively and immediately recognise how completely unacceptable this practice was, and how harmful and distressing it would be for families to find out that their loved ones were being photographed while they died is very troubling.

57. Bereaved families believe that they and their loved ones have been exploited.

Inadequate memorial and remembrance

58. The Covid-19 pandemic resulted in many thousands of deaths in Wales and a tsunami of grief. It requires a government-led healing process.

59. Research has shown that national moments of reflection and memorials are powerful ways to validate feelings of grief, promote healing, and foster a sense of unity. They also serve as a reminder of the importance of community and shared humanity.

60. The absence of an official national Covid-19 memorial in Wales and the inadequacy of remembrance events in Wales further prolongs the group's grief and serves to increase the sense of injustice. As one member put it: "by not organising a proper memorial or place of remembrance in Wales…the sheer way they are still trying to brush it under the carpet like it never happened, is an insult to us all."

61. The National Covid Memorial Wall remembrance wall outside St Thomas' Hospital (and by the Thames opposite Westminster) is a fitting memorial and many group members have found tremendous comfort through contributing to and visiting it.

62. In stark contrast there is nothing remotely similar in Wales, which has been typical of the post-pandemic response in Wales.

63. CBFJC continues to campaign for a fitting memorial at the Senedd in Cardiff, and the group feels strongly that this process ought to be led by the Welsh Government on behalf of the people it represents.

Lack of accountability

64. The CBFJC is acutely aware that the focus of this Module is the impact of Covid-19 on society, rather than on decision-making, and the group respects the Inquiry's decision in this regard.

65. While the group understands that the Inquiry cannot examine the actions of the Welsh Government in this Module it nevertheless hopes that it will be able to take account of the very significant and ongoing impact experienced by bereaved families at the failure of the Welsh Government to properly explain and take responsibility for their actions during the pandemic.

66. Such conduct has given rise to overwhelming anger and frustration, exacerbating grief and prolonging the bereavement process.

Failure to learn lessons

67. A big part of the reason why bereaved families came together and continue to campaign is to effect change to prevent others from ever having to go through the trauma they experienced, and continue to experience.

68. To witness the continued failure to learn lessons and implement necessary improvements leaves the bereaved with a sense of futility.

69. Not only have things not improved, they are worse than before the pandemic, with waiting lists still double pre-pandemic levels, healthcare estates that remain inadequate, testing capability and capacity that has not been maintained, and woefully inadequate IPC and PPE.

Ongoing impacts on wellbeing and mental health

70. As already mentioned, a common and enduring experience of bereaved families, is a feeling of guilt for not doing more or trying harder for a loved one. For example, those who accepted the rules feel that they should have done more and should have been more challenging and persistent, when they hear stories of families who through their tenacity and insistence were allowed to visit a loved one in a care home or hospital.

71. And those who followed the rules to their detriment continue to be outraged at the behaviour of those in privileged positions who did not.

72. Many bereaved continue to experience anxiety and depression, requiring ongoing medication and therapy and other treatments, from the experience of losing a loved one in such terrible circumstances, and it comes as no surprise to group members that levels of anxiety and depression among the general population remain at approximately double their pre-pandemic levels.

73. Despite all of these ongoing impacts the members of CBFJC remain as determined as ever in their pursuit of the truth and justice.

74. They repeat their thanks and appreciation to the Inquiry for the ability to participate in this important Module.

Covid-19 Bereaved Families for Justice Cymru

23 January 2026