Module 2a Week One

CTI Opening

There was prior to the pandemic no Welsh National Risk Register to take into account the specific circumstances in Wales. Although the risk of pandemic influenza was included in the risk register of the Welsh Government's health and social services group it was not identified as an important cross-government issue.

The evidence appears to be that the Welsh Government had not assessed how a pandemic had the potential to impact the individual profile of Wales and its population based for example on grounds of resources, age, socioeconomic status or underlying health.

Professor Nazroo identified that people living in care homes were a population who were at particular risk of complications or death if they experienced a respiratory viral infection. This is particularly the case for those living in nursing homes because of their higher level for medical need. He opined that residents in care homes were also at much greater risk of infection compared to those living in private accommodation close quarter living arrangements and other factors.

On 31 January the novel coronavirus was discussed by the UK Government Cabinet for the first time. The evidence suggests that Covid was not discussed by the Welsh Cabinet until nearly a whole month later on 25 February.

Does the fact that Covid was not discussed by the Welsh Cabinet throughout January indicate that the threat posed by the virus was not taken as seriously as it ought to have been, or that the Welsh Government thought the UK Government had things under control and there was no need to take independent action?

Should consideration have been given even at this relatively early stage not just to gearing up NHS preparedness but to declaring a major incident for health in Wales and standing up the Emergency Coordination Centre? During February, the evidence suggests that the virus was still not a priority of the Welsh Government.

10 March, the Welsh Cabinet met. The First Minister provided an update on Covid and said: with six cases in Wales now was not the time to introduce more restrictive measures on movement, if they were used prematurely it would likely lead to the population being less receptive to messages.

On 11 March the WHO declared Covid-19 a pandemic. Wales had its first case of community transmission.

Public Health Wales concluded that objectively the demographic characteristics of the Welsh population and specifically the age profile of the population over 65, health and economic status, and dependency responsibilities, are such that Wales may experience disproportionate levels of impact from Covid.

There is evidence that more than 1,000 Welsh patients were discharged from hospital to care homes without a test during March and April 2020.

As of 5 June, ONS figures suggest that nearly a third of Wales Covid-19 deaths had been within care homes. There is no doubt that the massive failure of infection control contributed at least in part to the influx of

infected but untested patients. The Welsh Government's position is that it was advised that testing would not be effective for those who were asymptomatic and there was in any event a lack of testing capacity. It is an issue for the Inquiry whether this belief could have been genuinely or sensibly held. There is clear evidence that by early April 2020 it was known that only testing those with symptoms missed up to half of care home infections.

Why it was not until 29 April 2020 that the Welsh Government policy changed to testing all patients discharged from hospital to a care home, regardless of whether they were showing symptoms. This was nearly two weeks later than the change in policy in England.

Firebreak

- On 18 September, with case numbers increasing, TAC advised the Welsh Government that the situation was serious and that a package of NPIs may be needed to bring the R rate below 1.
- On 25 September the need for early intervention was reiterated by TAC.
- On 2 October TACs advice to the Welsh Government was that unless measures bring R back below 1 hospital admissions may exceed scenario planning levels. In other words, unless further steps such as a circuit-breaker NHS in Wales would be overwhelmed.
- Despite this advice, the Welsh Cabinet did not meet to discuss a circuit-breaker until 15 October.
- On 19 October the First Minister announced that the Welsh firebreak lockdown would take effect from Friday 23 October for two weeks.

The Job Support Scheme which was to be the successor to the Coronavirus Job Retention Scheme was due to start on 1 Nov 2020. Further to the Welsh Cabinet's decision in principle to introduce a firebreak in Wales the First Minister asked the Chancellor of the Exchequer to start the scheme earlier in Wales, a request which was declined. The First Minister described that as one of the most misguided decisions of the whole pandemic.

CBFJ Cymru

12,510, the number of deaths registered in Wales where Covid-19 is mentioned on the death certificate as at 2 February 2024.

The Welsh Government has refused to open itself to scrutiny by establishing a Wales specific Inquiry.

Armed with scientific data, it was open to the Welsh Government as a devolved administration to act sooner. Why didn't it? Why did it blindly follow the UK Government in a case of the blind leading the blind?

The failure to heed the risk is unacceptable. One area where the failure to acknowledge risk of asymptomatic transmission had devastating consequences in Wales was in respect of the decision taken to discharge people from hospital into care homes without testing.

Why did Welsh Government delay in changing its policies to factor in the risks of asymptomatic transmission? The delay was akin to a death warrant for the elderly and a stark message that they did not matter.

SAGE recommended a firebreak but waited almost a month to put it in place. The Welsh Government appears to blame the UK Government funding decisions for the delay but there is clear evidence to refute this suggestion which we hope will be put to witnesses.

Mr Straw obo Johns Campaign

For those in care, one family member should have been appointed a key worker.

In the first three months of the pandemic, 39% of deaths in the UK were of care home residents. Many more were deaths of those receiving care outside the care home, for example in domiciliary care. There was a far higher rate of death of care home residents than in hospitals. There was also devastating indirect harm. This was an emergency within an emergency, and it should have received central attention by decision-makers, but it didn't. In many ways the care sector was overlooked.

83.3% of care home deaths were from causes other than Covid during the pandemic. In Welsh care homes, dementia and Alzheimer's remained the highest causes of death throughout the whole period.

Failure to listen to stakeholders: on 22 March 2020 Mr Gething was advised that isolation facilities in care homes would be put in place to manage these discharges. In fact, up to 58% of care homes did not feel able to effectively isolate suspected Covid-19 residents.

Sufficient PPE was not made available to those providing care, among others, during the first few months of the pandemic. Mr Gething suggests the answers include problems in systems for the distribution to social care, so PPE was sent to local authorities, but they did not forward it to care providers.

Danny Friedman KC obo DPO

68% of the people who had died of Covid were disabled people. In Wales it was 7 out of 10. We are learning that disabled people, when age is taken out of the equation, were at least three times more likely to die of Covid in Wales than non-disabled people.

It was the Welsh Government that initially acquiesced in the passing of legislation which suspended duties relevant to protecting disabled people at a point when those duties actually needed enhancing. It was an Act which singles out disabled people's most basic rights as something that can be switched off when expedient to do so. It was also under the Welsh Government's watch that the use of Do Not Resuscitate notices proliferated in an unaccountable fashion. It was a GP surgery in Maesteg, which suggested to elderly, frail and disabled people that it was better to use resources on the young and fit who were said to "have a greater chance of survival."

Mr Gardner obo Children's Commissioner for Wales

Children’s homes – usually small groups consistent with the bubble system or Rule of 6. Requiring children in these settings through official guidance to self-isolate for a minimum of 14 days upon every contact with Covid and to have their contact with their families completely stopped for lengthy and repeat periods of up to 28 days following any sort of outbreak was inconsistent with their risk profiles and their human rights.

Sam Jacobs obo TUC and TUC Wales

It was often the poorest in society who had the least ability to comply with measures, the least opportunity to work from home, and were most exposed to the virus in health settings and in service jobs. Those who were generally less well off with greater disadvantage and vulnerability paid the greater price. It was the price paid by people who kept parcels being delivered to our door, processed our food, who stacked our shelves, who cared for our sick and elderly and many others.

Mr Allen KC obo WLGA

Whatever policies were announced centrally, they had to be delivered locally. However apt and well designed central government policies may appear to be, the success of their delivery will always depend on the capacity of those organisations tasked with their operationalisation.

The Welsh Government could have harnessed the Local Authority Directors of Public Protection. These bodies could have done more, had they known more about the disease and the measures chosen to mitigate its impact, including having more expert resource prepared and available, along with the provision of advice on social gatherings and events.

The market was flooded with fraudulent or substandard PPE, and indeed the supply and control of it was inconsistent, failed to meet the required standards on some occasions, and was often described falsely. Local authorities have a better understanding of the trade sectors and the enforcement responsibility to challenge non-compliant products.

Mr Kinnier obo Welsh Govt

The Welsh Government is concerned that the concept of divergence suggests that the policy of the UK Government is the benchmark against which the Welsh Government's decision-making will and indeed should be considered.

The Treasury's unresponsiveness to the need and public health requirements of the devolved governments meant that actions taken by the Treasury to put in place interventions were based solely on instructions from central government.

Day 2

Elizabeth Grant - Covid Bereaved Families for Justice Cymru group

Mother passed away on 19 April 2020 age 86.

I got the medical records later and it showed a DNR was placed on her. This is not something she wanted. There was also a note that she should not be transferred to an acute hospital.

Transferring patients from ward to ward, hospital to hospital, hospital to home/care homes untested. That changed to mandatory testing in England on 16 April but it was not introduced until 29 April 2020. We want to know why that was delayed.

The Welsh Government mandated the wearing of masks two months after the UK Government.

Amanda Provis - Covid Bereaved Families for Justice Cymru

Mother died 7 April 2020 at age of 61. Father worked as a hospital porter – had no PPE. It is likely he brought it home. Mother started to show symptoms but was never advised to go to hospital.

Also lost my grandmother. She had a fall in May and broke her hip so was admitted to hospital. She was tested when she was discharged to a care home. It was negative. When she tested positive the only treatment was paracetamol. They did not attempt to transfer her to hospital.

Professor Emmanuel Ogbonna - Prof. of Management and Organisation at Cardiff University and Vice-chair of Race Council Wales)

Part of the First Minister's Black, Asian and Minority Ethnic Covid-19 Advisory Group.

The first ten doctors to die from Covid-19 were from Black, Asian and ethnic minority groups. A disproportionate number of nurses and other healthcare workers that have lost their lives have also been from Black, Asian and ethnic minority communities.

We wrote to Dr Atherton, the Chief Medical Officer for Wales, in April 2020, expressing concerns about the disproportionate impact. The First Minister acted promptly and two weeks later on 29 April, he established the Black, Asian and Minority Ethnic Covid-19 Advisory Group to look into the issues that had been raised.

Ethnicity is not recorded on death certificates which means accurate statistics on death rates are not known and you might not know the extent of the problem.

Developed anti-racist Wales action plan. Wales is the only nation in the world that has tried this approach. It has multiple complexities but it is a work in progress and the people that are doing it are committed to getting it right.

Prof. Debbie Foster (Prof. of Employment Relations and Diversity at Cardiff University)

Medical Model of disability defines people by what is wrong/different about them so negative in their approach. The social/individual model of disability says that instead of focussing on someone's medical condition or impairment, we should be focussing on the barriers in society that do not allow them to function as others can and access what everybody else can. It puts the onus back on society as to whether you disable someone or not. The idea is that somebody isn't necessarily disabled by their impairment, they are usually disabled by the inability of society to accommodate that impairment.

All Governments in the UK reverted to the medical model in responding to the pandemic.

There was a feeling amongst the group that disabled people were generally seen throughout Covid as dispensable. It was not inevitable that disabled people were necessarily going to die in larger numbers than other groups of the population. There were things that could and should have been done. Whilst suffering from the direct harm of the virus itself, disabled people were also suffering as a result of reduced access to non-Covid services.

Helena Herklots CBE (Older People's Commissioner for Wales)

I called for the Welsh Government to create a new post of Chief Social Care Officer which the Welsh Government did in fact introduce in June 2021. I called for this because my assessment was that social care was not seen as on parity with the health service and needed to be.

GPs had stopped visiting care homes leaving them without support. Also concerns about access to hospital treatment. I was concerned whether there was any blanket policy in place, so I was really looking for assurance that that wasn't the case and that older people in care homes would not somehow be seen as less in need of healthcare or medical treatment because they were living in a care home.

When the deaths were starting to be published, initially people dying in care homes weren't included in that data. I don't know why that was.

There was a letter that came out from a GP surgery, I think, in very early April, that was sent out to a number of its older patients and people living with frailty, saying that it wanted to complete DNACPR for them. It went on to say that if they fell ill or needed treatment, they shouldn't call 999 and that scarce resources would be directed to those who were young and fit and more able to benefit. So it very starkly set out how older people were being viewed at that time.

I raised that and an apology was issued but that stayed with people. It really broke the trust that some older people had with the NHS.

They felt that maybe they wouldn't get the treatment that they needed. And the other thing that was happening at the same time was that the messaging about protect the NHS I think was having a damaging effect on some older people as well who felt that they shouldn't approach even when they were ill, so that it deterred them from seeking help when I think they should have done.

It is my view that people in care homes were not given a sufficiently high priority. I felt that social care was definitely seen as secondary to the health service including wages, the way in which society talks about social care, it doesn't feature in the way that people talk about the NHS, the huge focus on hospitals, understandably, but I think it meant that care homes were sometimes viewed as places primarily there to accept people who were being discharged from hospital rather than as people's homes.

Prof. Sally Holland (former Children's Commissioner for Wales)

The impact was immediate, but we are now also seeing it long term in terms of confidence to attend school. It has had a profound affect.

Childrens Rights Impact Assessments were not carried out at the time decisions were taken including the closure of schools. We can see examples where children's specific needs, as a population category, were not being considered.

Day 3

Prof. Dan Wincott (Expert in decision making in Welsh Government)

Professor of law and society in the School of Law and Politics.

The expectation of the First Minister was that the UK would take decisions for the whole of the UK and that was the expectation across all the devolved authorities. So the approach that was taken by implementing the Coronavirus Act under public health was not anticipated. There has been debate about whether that was the right approach.

The Welsh Firebreak 23 Oct 2020 – 9 Nov 2020 was the clearest example of Welsh adopting a starkly different policy to UK Government and the other Devolved Authorities. The Treasury did not agree to extend the furlough scheme to cover the Welsh firebreak. This illustrates a point of the difficulties faced by the Welsh Government not having the fiscal levers to support individuals and businesses that could not earn income during the Pandemic.

There was an opportunity for the Welsh Government to be better prepared for the second wave of the pandemic in autumn 2020, having been through obviously the first wave in the spring of 2020.

Prof. Sir Ian Diamond (Chief Executive of UK Statistics Authority, National Statistician and Permanent Secretary)

Excess Deaths

- England had the highest percentage of excess deaths registrations when looking at the whole time period, and also two of the three lockdown periods.
- This was true when looking at excess deaths using either numbers of death registrations or age-standardised mortality rates.
- During the second wave, Wales fared the worst in the second lockdown.

Mortality in Wales was very largely restricted to the elderly. We know from other places that often there were comorbidities that may have played a role in mortality for younger people. We don't see that very much in Wales.

We saw a significant increase in deaths at home in Wales. Some of that could be Covid, others it could be cardiovascular disease where people had not gone into hospital. We also see a significant increase in deaths in care homes.

Stephanie Howarth (Chief Statistician and Head of Profession for statistics to the Welsh Government)

Problems with data include the fact that there was no data differentiating community acquired infections from hospital-acquired infections meaning that the case load of Covid-19 in the community could be overestimated or underestimated. Also data did not distinguish between the number of patients admitted due to Covid-19 compared to the numbers admitted for a different reason but who happened to have Covid-19.

The ONS data doesn't necessarily tell you about “in service” deaths from Covid-19. It would tell you whether someone had died from Covid-19 but not necessarily whether the infection was acquired in the line of work.

Dr Robert Hoyle (Head of Science, Welsh Government Office for Science)

Main role is to support the Chief Scientific Advisor for Wales (Prof Halligen).

It was obvious in mid Feb that a major intervention would be required. It was obvious from the rate it was spreading and what we were seeing in other countries within communities but also across the world. It was virtually unstoppable. That was not a commonly held view at that time. I think it was dawning on the CSA.

It started to be discussed in the CSA for Wales (Prof Halligen) office in the week before lockdown. I had been monitoring this since 2019. I had raised it a number of times with the CSA and his view was that this wasn’t an issue for him, it was someone else's problem. He thought it was an issue for health. I went out of my way to encourage him to engage in this and to do things. He eventually took that advice, but not until very late in the day. I think he could and should have done more.

The lockdown in March was necessary. It was inevitable because of the spread of the virus. I think by the time January came along it was already too late to avoid a lockdown. At the time I thought lockdown should have been earlier. Possibly 2 weeks earlier but I think 5-7 days earlier would have been appropriate. The virus needed to become prominent enough in people’s minds and the threat obvious enough for lockdown to work.

I think it would have been untenable for the Welsh Government to make a unilateral lockdown ahead of a UK national lockdown. I think ministers realised that, because we are such a small part of the UK in population terms. I think there would have been huge challenges in getting the population to accept it, and not only that, the political ramifications and accusations so I think it was a national lockdown or nothing.

An earlier lockdown would have smoothed the peak, it would have prevented as many people being infected, and it would have reduced the number of fatalities in the first wave.

Eat Out to Help Out in a small way contributed to the re-emergence into a new peak, but no more so than many of the other release activities that were going on at the time through the summer of 2020, allowing people to go on holiday and that kind of thing.

Wales mandated the use of face masks on 14 September 2020, which was significantly later than other European countries and later certainly than England, Scotland and Northern Ireland. It should have been mandated much earlier. At least as early as the other nations of the UK.

Day 4

Dr Chris Williams (Consultant Epidemiologist for Public Health Wales)

Timing of interventions was critical. Early intervention leads to quicker results. Lockdown in Wales was not recommended earlier because the overall strategy that we were following was a UK strategy. The Chief Medical Officers had made an agreement that they were going to attempt to do the same thing at the same time, except where there were specific reasons for a different response, because of differences in the NHS structure or whatever. So we were following a UK response. I don't think it would have been feasible to lockdown without the UK Government.

I did wonder whether we, including myself, could have done more to argue for an earlier lockdown, given that the UK-wide lockdown didn't happen when we thought it might have done. I have wondered about whether I should have argued harder for something to be done, but I'm not sure it would have made an awful lot of difference.

My view is that the UK should have locked down earlier, ideally on 12 March or possibly even earlier than that. Partly because of what the modelling was saying in terms of the timing of a lockdown in relation to the impact, and also partly because we had evidence that it would work from Wuhan and Italy.

I think it would have reduced the impact on the first wave in terms of hospitalisations and deaths. However, it might have been that there would have been a rebound effect over the second wave and we did see that to an extent, that we were actually slightly less impacted relative to population in the first wave but then slightly more in the second wave. So to an extent, what you don't get in one wave, you do get later on, unless it's a very well enacted and early suppression the second time.

Professionally I would have assumed that there was likely to have been asymptomatic infection. I can't say whether it would have been better to assume asymptomatic transmission as there would have been implications to it. But yes, it's always worth considering on the precautionary basis what might be transmission routes.

I argued for routine testing of Health Care Workers. Symptom based screening alone would fail to identify Covid-19 cases. Routine screening of everyone, so symptomatic and asymptomatic, was really the only effective way to avoid transmission of Covid-19 from staff bringing community infections into a care home.

Dr Roland Salmon (Senior Crematorium Medical Referee for the Cardiff Council Crematorium and former Director of Communicable Diseases for Public Health Wales)

I would have gone for Focussed Protection rather than a lockdown for everyone. It would have been possible to detach the epidemics that were taking place among vulnerable populations in places like hospital and care homes from the wider transmission in the community. I think that transmission in the community might reasonably have been expected to bring with it a measure of protection.

Essentially for the vulnerable population Focussed Protection doesn't look terribly different from the lockdown that they had already. What is rather easier for them, however, is that services around them should be working rather better.

The other problem that we have is the lack of capacity in our acute hospital sector, our hospitals run often at 85% to 90% occupancy all the time. With that you really don't have the space and resilience for efficient and effective infection control. One way around that might have been to have used the Nightingale hospitals for step-down care rather than imagine that they would have been used for acute care, but as far as I can see that never happened either.

Prof. Ann John (Professor of Public Health and Psychiatry at Swansea University)

Understanding why people may follow rules and their motivations is really important when thinking how do we encourage people to behave in certain ways? The vast majority of people adhered to the restrictions that were in place, and where they didn't, it was for the things like not having access to financial support to self-isolate, it was not having the support to go and get a food shop or walk their dog.

One of the basic principles of behavioural science and communication is having clear messages where you explain why you've come to that policy decision. Divergence across Nations would have been very confusing to people. Unless you gave a very clear explanation for that divergence, especially when both are claiming to follow the science, it would have affected some segments of the population.

Prof. Michael Gravenor (Professor of Biostatistics and Epidemiology at Swansea University)

Herd immunity never seemed a sensible conclusion because viruses are extremely adept at changing and so there was always going to be concerns over immunity. I think this is before the term Long Covid was mentioned but systemic nasty respiratory viruses cause damage and we don't know the problems there. But in terms of large-scale emergency response, then shutting activities down and reducing contacts a lot has always been part of discussions of pandemic response.

In retrospect an earlier lockdown would have been helpful. Modelling suggested that if the lockdown had been introduced 5 days earlier 24% of deaths may have been prevented.

The late lockdown meant we had a very high prevalence of infection throughout April and early May in the UK, and any effort to keep an infectious disease out of a risky environment such as a hospital or a care home is more difficult if the prevalence in the community is higher. We've since looked at the relationship between the prevalence in the community and risks in care homes, and there is a significant association between the two in that clearly infection control is likely to be easier if the prevalence in the community is not so high.

I can’t comment on the impact of EOTHO but any increase in mixing is going to increase RT and accelerate the arrival of the autumn wave. The extent to which it happened I really don't know.

Acting earlier suppresses it to a lower level and delays the next action. Waiting longer means you have to either act more severely to bring it down to very low levels or you are acting to bring it down to a somewhat lower prevalence from which it will return as well.

Q: The First Minister's provided a statement in which he said that the firebreak produced the gains which had been expected but that the gains were much more short lived than the modelling available to the Welsh Government had anticipated.

A: That is not correct. The model contained the assumption that we would return to exactly the same R level and worked out how long that would take. The model projected a return with 38 days and the actual return was 39 to 40 days.

An earlier firebreak would have helped but I do believe the timing was just about right but having it at the lower end of duration was always going to have minimum impact. I do think it should have been for longer. It was somewhat unfortunate to come out of the firebreak into the highest transmission period.

In December, with the emergence of the Alpha variant which went on to make up a very, very substantial part of the second wave. So whilst there were measures going on in early December, they clearly weren't enough.