

Agenda – Wales COVID–19 Inquiry Special Purpose Committee

Meeting Venue:

Committee Room 3, Senedd

Meeting date: 10 March 2025

Meeting time: 14.00 – 15.00

For further information contact:

Fay Bowen

Committee Clerk

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Private Meeting

(14:00 – 15:00)

At its meeting on 17 February, the Committee agreed under Standing Order 17.42(ix), to resolve to exclude the public from today's meeting.

1 Introduction, apologies, substitutions and declarations of interest

(14:00)

2 Papers to Note

(14:00 – 14:10)

2.1 Letter from the Petitions Committee to the Wales COVID–19 Inquiry Special Purpose Committee Co–Chairs – Petition P–06–1450

(Pages 1 – 8)

2.2 Letter from the UK Covid–19 Inquiry to the Wales COVID–19 Inquiry Special Purpose Committee Co–Chairs

(Pages 9 – 12)

3 Consideration of the Module 1 Motion Draft Report

(14:10 – 15:00)

(Pages 13 – 37)



Tom Giffard MS, Wales COVID-19 Inquiry Special
Purpose Committee, Co-Chair

Joyce Watson MS, Wales COVID-19 Inquiry Special
Purpose Committee, Co-Chair

18 February 2025

Dear Tom and Joyce,

Petition P-06-1450 Welsh Government to take action to protect people from airborne infections in health care settings

The Petitions Committee considered the above petition, submitted by Anna-Louise Marsh-Rees, at its 3 February meeting.

In discussing the petition, Members noted the work being done on these issues in the Senedd, including by your Committee. Members agreed that, because of the nature of what the petition and petitioner are asking for, that the Petitions Committee was not the best place to take the issues any further. Members therefore agreed to close the petition but to forward the petitioner's latest response to the Cabinet Secretary for Health and Social Care and the Special Purpose Committee, for awareness.

The full details of the Committee's consideration of the petition, including the correspondence and the actions agreed by the Committee can be found here: [P-06-1450 Welsh Government to take action to protect people from airborne infections in health care settings](#)

I would be grateful if you could send your response by e-mail to the clerking team at petitions@senedd.wales.

Yours sincerely



Carolyn Thomas MS
Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

<https://petitions.senedd.wales/petitions/245982>

Welsh Government to take action to protect people from airborne infections in health care settings

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25 Jan 2025

Dear Senedd Petitions Committee

The response from Covid-19 Bereaved Families for Justice Cymru to the Cabinet Secretary for Health & Social Care's letter to the Petition Committee dated 18 Dec 2024

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The Minister's assertion that "for most people, Covid-19 is like any other common respiratory illness" and that any intervention is futile is the fundamental issue.

He is rejecting the precautionary principle which must be applied to a novel virus. He is also clearly ignorant of the immune suppression caused by SARS-CoV-2, its affinity for vascular and other cell tissue and the risk of Long Covid.

He is unaware that immunity to infection induced by 'natural infection' wanes quite rapidly:

[https://www.thelancet.com/journals/ebiom/article/PIIS2352-3964\(22\)00584-9/fulltext](https://www.thelancet.com/journals/ebiom/article/PIIS2352-3964(22)00584-9/fulltext)

As does that provided by vaccination: "Doses offer time-limited protection, protection increases after each dose but then wanes over the following few months"

<https://www.gov.uk/government/publications/covid-19-vaccination-programme-guidance-for-healthcare->

[practitioners/covid-19-vaccination-programme-information-for-healthcare-practitioners](#)

For all these reasons, hospital-acquired infection should be avoided.

The comparison of current Covid admission statistics with those from earlier in the pandemic is unscientific and deeply flawed due to the changed criteria for testing. The testing of everyone on admission for surveillance purposes was universal in the early years, but since April 2023 testing has only been undertaken on admission when deemed clinically necessary. So, the signal is not consistent across that change of policy.

Given that up to 50% of infectious people are asymptomatic he should double the currently published admissions figures for a more realistic number. This greatly tempers the Welsh Government's claim of decreasing levels of Covid admissions.

As Health Minister, he cannot be excused for not knowing the current level of nosocomial SARS-CoV-2 infection in NHS hospitals in Wales. The data used to be quite obscure, but it is now published in the PHW Weekly Influenza and ARI Report, which he must read regularly.

<https://phw.nhs.wales/topics/immunisation-and-vaccines/flu vaccine/weekly-influenza-and-acute-respiratory-infection-report/>

His response focuses solely on the risk to a healthcare worker (HCW) from an infectious patient, not the risk to the patient from an infectious HCW. His assumption that the cause of hospital-acquired Covid is patients with community acquired Covid is inaccurate. If that is the case, then the testing of patients on admittance and every 3 days then isolate would immediately address this. There must be recognition that

infectious healthcare workers are transmitting Covid to patients. These patients who are already unwell & vulnerable, they have no way to protect themselves from Covid whilst in hospital.

The Minister has a duty to provide upfront protection of the already vulnerable in hospitals. Providing a test & treatment only when symptomatic is not adhering to the precautionary principle. The Minister & Welsh Government must act now to mitigate airborne viruses in hospitals.

We have provided further questions and recommendations to each point in the letter:

1. Airborne vs. Droplet Transmission:

-There's an overemphasis on droplet transmission in the response. He states "Person-to-person transmission of Covid-19 primarily occurs through direct transmission (involving droplets which land on mucous membranes) or by airborne transmission" and focuses heavily on surgical masks for droplet protection.

- 'direct transmission' - is not a term not used to describe any form of transmission and has no scientific meaning

- See Professor Clive Beggs definitive and expert report to the UK Covid Inquiry on the physical sciences underpinning Covid-19 transmission and its implications for infection prevention and control in healthcare settings'

<https://covid19.public-inquiry.uk/documents/inq000474276-expert-report-by-professor-clive-beggs-titled-an-expert-report-on-the-physical-sciences-underpinning-covid-19-transmission-and-its-implications-for-infection-prevention-and-control-in-h/>

- Improvement needed: He must acknowledge that COVID-19 is predominantly airborne and adjust the protective measures accordingly:

- Prioritize proper ventilation and air filtration
- Emphasise the use of well-fitting respirators (FFP3 or to an equivalent standard approved by the HSE) as Cambridge did)

- Implement air quality monitoring more systematically eg Addenbrookes

2. Long-term Health Impacts:

- There's no acknowledgment of Long COVID or chronic health impacts of Covid from even a mild initial infection and especially repeated infection.
- Improvement needed:
 - Include risk assessment for long-term health impacts
 - Develop protocols specifically aimed at preventing chronic complications
 - Consider long COVID impact on healthcare workforce planning

3. Ventilation Monitoring:

- Current approach seems fragmented:
 - No centralized reporting of ventilation status
 - CO2 monitoring not included in testing requirements
 - Ad-hoc testing based on individual Ventilation Safety Group decisions
- Improvement needed:
 - Implement mandatory CO2 monitoring and data-logging
 - Create centralized reporting system for ventilation status
 - Set minimum ventilation standards that must be met

4. Testing Strategy:

- His position on reduced testing seems based primarily on population immunity. There is no immunity from Corona Viruses ever and a 'current' reduction in acute reactions but no change in long term chronic problems from a neurovascular chronic infection.
- Improvement needed:
 - Reintroduce and mandate regular testing of HCWs and patients
 - Stop HCWs working when infectious with Covid -both asymptomatic & pre-symptomatic

- Encourage HCW uptake of Covid vaccination as currently low in Wales
- Include asymptomatic Covid stats in nosocomial reporting
- Implement strategic surveillance testing
- Account for chronic virus persistence and to be proactive on new circulating variants
- Recommence the Wastewater in Wales -sampling weekly alerts. The award-winning programme was one of the best in the world, led by one of the currently most published scientists in Wales. It gave an indication of regional infection prevalence and variant dynamics across Wales, important both to inform NHS and Public Health policy in Wales, especially giving advanced warning of likely hospital admissions and feeding into global surveillance, as requested by WHO.

5. Air Purification:

- The response indicates no standardized approach: eg CADR
 - No recognised industry standard for testing
 - No systematic monitoring of infection rates in relation to air purifier use
- Improvement needed:
 - Develop standardised testing protocols
 - Conduct systematic studies on effectiveness
 - Create clear guidelines for when, where and how much air purification is required for each level of risk.

6. Staff Protection:

- Focus seems to be on managing sickness absence rather than prevention. This is already a huge problem, from viral persistence and immune T-Cell exhaustion (aka Leonardi effect)
- Improvement needed:
 - Implement proactive protection measures inc regular testing
 - Provide high-quality respiratory protection i.e HSE requirements = FFP3 or equivalent, such as elastomeric reusable or Powered Air Purifying Respirators)

- Mandatory regular IPC training & not a reliance on manuals - they don't protect anyone.
- Regular risk assessments considering airborne transmission.

7. Nosocomial Covid Protection

- Over the past year 60% or more of NHS inpatients in Wales with Covid acquired it in hospital. These are just inpatients who have been tested because their symptoms are of clinical concern to the Consultant. There will be many more untested. For example, 05 January 2025, there were 176 inpatients in Welsh NHS hospitals with confirmed Covid infection, 111 of which (63%) had acquired it nosocomially.
- The current IPC measures in place cannot therefore be described as effective when there are so many nosocomial cases of Covid, flu etc in hospitals in Wales
- Improvement needed:
 - implement all the above plus:
 - Introduce Welsh Government targets to reduce nosocomial infection

Regards

Anna-Louise Marsh-Rees

Group Lead

Covid-19 Bereaved Families for Justice Cymru

Agenda Item 2.2



contact@covid19.public-inquiry.uk

Our reference: 2500011561

Joyce Watson MS and Tom Giffard MS
Wales COVID-19 Inquiry Special Purpose Committee
Welsh Parliament
Cardiff Bay
Cardiff
CF99 1SN

25 February 2025

Dear Ms Watson and Mr Giffard,

Thank you for your letter of 30 January 2025 and update regarding the work of the Wales COVID-19 Inquiry Special Purpose Committee. I will respond to each of the Committee's queries in turn below.

Health inequalities

The Inquiry's [Terms of Reference](#) include a specific focus on disparities evident in the impact of the pandemic on different groups of people. This includes people who share different protected characteristics, people in different nations and regions, different occupational groups and people from different socio-economic backgrounds and immigration status. This approach has been further set out in our [Equalities and Human Rights Statement](#).

Inequalities, including health inequalities, are being considered on a module by module basis as appropriate to their individual scopes.

In [Module 1](#) (Resilience and Preparedness) the Inquiry instructed two leading inequalities experts, Professor Sir Michael Marmot and Professor Clare Bamba, to provide an expert report focussing on the impact of Covid-19 on health inequalities and how such inequalities were considered by decision-makers throughout the pandemic.

The [Module 2](#) (Core UK Decision Making and Political Governance) investigation considered the extent to which decision-makers took into account pre-existing inequalities, including race and other protected characteristics. The following experts produced reports to assist in this regard, covering the position across the four nations: Professor James Nazroo, Dr Clare Wenham, Professor Laia Becares and Professor David Taylor-Robinson. The expert reports can be found on the [Documents](#) page of the UK Covid-19 Inquiry website under the tab 'Evidence'. In addition, Module 2B took evidence on inequalities issues in Wales specifically. For example, the Chair heard from the Older People's Commissioner for Wales, the Children's

Commissioner for Wales, the Race Council Cymru and the Welsh Government's Disability Equality Forum.

Health inequalities were also referenced in the expert reports published in [Module 3](#) (UK Healthcare Systems). For example, Professor Chris E Brightling and Dr Rachael Evans explored Long Covid treatment and health inequalities as part of their expert report on The Treatment of Long Covid, and Professor Helen Snooks made an observation about the recognition of health inequalities as part of her expert report on Emergency Prehospital Care and Shielding.

In [Module 4](#) (Vaccines and Therapeutics), the Chair heard from Dr Kasstan-Dabush and Dr Chantler, who produced a report considering issues such as disparities in vaccine coverage, the causes of disparities, the reasons for barriers to uptake and the interplay between the vaccines roll-out and pre-existing inequalities and structural discrimination. The Chair also heard from experts on vaccine hesitancy amongst specific groups and on vaccine safety and therapeutics, both of which considered equalities elements including diversity in clinical trials and treatments.

All of these expert reports can now be found on the Inquiry website.

[Module 10](#) (Impact on Society) will examine inequalities relating to mental health, including through the commissioning of a systematic evidence review. The review will compare changes in the mental health and wellbeing of the population during the pandemic against pre-pandemic trends, focussing on UK research, identifying any risk and protective factors for changes and whether there were any disparities in mental health outcomes based on equality characteristics. The module is also instructing two psychiatric experts, Professors Jayati Das-Munshi and Professor David Osborn, to produce a joint expert report into the impact of the pandemic on people with pre-existing and severe mental health conditions, including the disproportionate impact on individuals from a range of specific socio-demographic backgrounds. The module will also cover any inequalities in health outcomes specifically for key workers, examining differences across infections, mortality and mental health and wellbeing, compared to the general population. Lastly, it will examine any disproportionate effects on those most vulnerable within society, including those outlined in the Inquiry's Equalities Statement, as well as Clinically Vulnerable and Clinically Extremely Vulnerable people.

Mental health

Mental health is being considered by the Inquiry on a module-by-module basis where relevant to the scope. For example, an expert report published for Module 3 by Dr Guy Northover and Dr Sacha Evans focussed on the impact of the pandemic on treatment of non-covid conditions with a focus on Child and Adolescent Mental Health Services. Module 3 has also taken evidence on the impact of the pandemic on the mental health and wellbeing of healthcare workers.

[Module 8](#) (Children and Young People) is considering the impact of the pandemic on the mental health and wellbeing of children and young people. This includes hearing directly from children and young people about how the pandemic affected them, including their mental health and wellbeing, via the Inquiry's Children and Young People's Voices research project. The research is reflective of the UK population, including a mix of ages (currently aged between 9 to 22, who were between 5 to 18 at the start of the pandemic), ethnicities, genders, socio-economic backgrounds, those living in various geographical regions and those identifying as LGBTQ+ if aged 18 and over. The project is also hearing from children and young people who have been disproportionately affected by the pandemic. This includes children and young people with disabilities or health conditions, those in contact with mental health services, the criminal justice system, social services, the immigration system, and a range of other experiences during the pandemic and those who were in particular settings during the pandemic. Further information is available [here](#).

Mental health is a key topic within the provisional scope published for Module 10. As referred to above, this module is exploring the impact on mental health and the wellbeing of the general UK population, inequalities between different demographics, and mental health service provision. Module 10 is also looking at post-bereavement support, and support for people whose personal circumstances made them more vulnerable during the pandemic. The preliminary hearing, held on 18 February 2025, outlined the module's investigation and evidence gathering process in more detail.

The Inquiry's listening exercise, Every Story Matters, is also a rich source of data on mental health through the stories that individuals have shared with the Inquiry.

Listening exercise

Each story shared with us through Every Story Matters is being collated and analysed and will contribute towards themed records, which are submitted into each relevant investigation as evidence. Two of these records have already been published on our [Documents](#) page, the first covering Module 3 (Healthcare) and the most recent on Module 4 (Vaccines and Therapeutics).

There will not be an Every Story Matters record for [Module 5](#) (Procurement) as the Inquiry concluded that a record of personal stories would add limited further value to the investigation given its technical nature. All other future Inquiry modules will have Every Story Matters records. These records will be published at the start of each module hearing or shortly beforehand. The confirmed dates of future module hearings are published on the [Hearings](#) page of our website.

We have heard from more than 54,000 people so far through the Every Story Matters listening exercise, from across the UK. Three of the Inquiry's 25 public Every Story Matters events have been held in Wales (Wrexham, Llandudno and Swansea). In Cardiff, the Chair met with bereaved families to listen to their stories and in the last three years the Inquiry has met members of the public at events across North and South Wales. We have visited rural

communities at the Royal Welsh Show in Builth Wells, spoken to bereaved families and care home residents in Ruthin and Wrexham, and heard stories from people from disadvantaged groups and a variety of backgrounds at targeted events. All Every Story Matters resources are available in Welsh, people can share their story with a Welsh speaker and receive counselling support in Welsh at all events in Wales.

Reporting timetable

The Inquiry will be publishing detailed reports for each module, containing key analysis, findings and recommendations. The Module 2 report is expected to be published in late 2025, with the Module 3 report following in the Spring of 2026. Unfortunately, we cannot at this stage share a timetable for the publication of future module reports owing to the unique scope and nature of each of the modules.

Yours sincerely,



Ben Connah
Secretary
UK Covid-19 Inquiry

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By virtue of paragraph(s) ix of Standing Order 17.42

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