P-06-1262 Welsh Government to hold a public inquiry into decisions taken by them before & during the pandemic

Following first hearing in the UK Covid-19 Inquiry in June 2023 it has further demonstrated the need for a Wales specific public judge -led independent Covid inquiry,

Module 1 of the UK Covid Inquiry, which examined pandemic preparedness lasted six weeks, yet the focus on the Welsh Government was limited to just over 2 days. There were just 7 witnesses from Wales called providing just 8 hours of testimony from a total of 87 hours. This lopsided approach did not adequately scrutinise why the Welsh Government did not prepare for a pandemic.

Furthermore, the location of the committee in London poses significant barriers for Welsh bereaved families who are unable to easily travel there to participate.

In the First Minister, Mark Drakeford's letter to the sponsor for the UK Inquiry, Boris Johnson, dated 12 Nov 2021, he writes:

Evidence hearings in Wales. *Public participation in Wales will only be effective if the inquiry has a significant presence and visibility in Wales throughout the duration of the inquiry. It will be essential that resources should be made available for testimony to be given in the Welsh language, at the request of Welsh-speaking participants.*

Of the 7 modules already announced only Module 2B will be located in Wales, with only 13 working days covering the Welsh Government response.

Module 3 examining healthcare, the most important module, is scheduled for 10 weeks only. Its scope is vast inc. Preparedness. Core decision-making and leadership within healthcare systems. Staffing levels and critical care capacity. The establishment and use of Nightingale hospitals and the use of private hospitals, 111, 999 and ambulance services. GP surgeries and hospitals and cross-sectional co-operation between services. Healthcare provision and treatment for patients with Covid-19. Healthcare systems' response to clinical trials and research during the pandemic. The allocation of staff and resources. The impact on those requiring care for reasons other than Covid-19. Quality of treatment for Covid-19 and non- Covid-19 patients, delays in treatment, waiting lists and people not seeking or receiving treatment. Palliative care. The discharge of patients from hospital. Decision-making about the nature of healthcare to be provided for patients with Covid-19, its escalation and the provision of cardiopulmonary resuscitation, including the use of do not attempt cardiopulmonary resuscitation instructions (DNACPRs).The impact of the pandemic on doctors, nurses and other healthcare staff, including on those in training and specific groups of healthcare workers (for example by reference to ethnic background). Availability of healthcare staff. The NHS surcharge for non-UK healthcare staff and the decision to remove the surcharge. Preventing the spread of Covid-19 within healthcare settings, including infection control, the adequacy of PPE and rules about visiting those in hospital. Communication with patients with Covid-19 and their loved ones about patients' condition and treatment, including discussions about DNACPRs. Deaths caused by the Covid-19 pandemic, in terms of the numbers, classification and recording of deaths, including the impact on specific groups of healthcare workers, for example by reference to ethnic background and geographical location. Shielding and the impact on the clinically vulnerable (including those referred to as "clinically extremely vulnerable"). Characterisation and identification of Post-Covid Condition (including the condition referred to as long Covid) and its diagnosis and treatment.

Module 3 is not even split by nation despite healthcare being fully devolved and each nation having their own system.

In England alone, there are 229 NHS Trusts and 43 Integrated Health Boards, 220 general acute hospitals, 826 community providers and 6,925 GP practices.

It will simply not be possible to cover even England in this time let alone scrutinise Wales and the other devolved nations.

The absence of Welsh experts or even experts that include Wales in their reports in the UK Inquiry further undermines its ability to comprehensively assess the Welsh context and provide meaningful insights.

The First Minister stressed he would only be in a UK Inquiry if it was in Wales, in Welsh and with Welsh experts yet that is not happening.

In stark contrast, Scotland has set an exemplary standard for devolved governments by establishing a separate Scottish Covid Inquiry that collaborates with the UK Covid Inquiry. This joint effort ensures there is no duplication and gaps and guarantees thorough scrutiny of Scotland's response.

For Wales, we demand more than a Senedd Special Purposes Covid Committee that operates behind closed doors and within the same political arena where Welsh decision making occurs. It is imperative that the Wales Covid inquiry is conducted independently and led by a judge, ensuring transparency, impartiality, and public trust. Additionally, the current committee's lack of enforcement powers, limited only to producing a report, fails to provide the necessary mechanisms for holding accountable those responsible for any shortcomings identified.

We continue to call for a Wales specific independent, judge-led public inquiry that incorporates the valuable lessons learned from Scotland's approach and prioritises meaningful participation of bereaved families in the proceedings. It is only through such a comprehensive and inclusive inquiry that we can hope to achieve justice, accountability, and the prevention of future tragedies.

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Regards