Witness Name: The People’s Care Watchdog

Statement No: 1

Exhibits:

Dated:

UK COVID 19 INQUIRY

WITNESS STATEMENT OF THE PEOPLE’S CARE WATCHDOG

We, Leandra Ashton, Patricia Myers and Sasha Paterson of the People’s Care Watchdog, will say as follows:

1. We make this statement pursuant to a Rule 9 Request from the UK Covid-19 Inquiry in relation to Module 6 dated 30 July 2024

History Of The People’s Care Watchdog

2. The People's Care Watchdog (“PWC) exists solely because of the Covid-19 crisis. We were initially just three people – Sasha Paterson, Leandra Ashton and Fiona Gowrley - with loved ones in care homes. We realised that care home families desperately needed legal advice in relation to the visiting bans so that rights could be asserted and residents protected.

3. However, once we had a clearer picture of quite how awful things were across the care home sector, things snowballed very quickly. We started giving as much one to one support as the founders could manage between them; and as much advocacy work as our one retired social work manager could manage. We were working pro bono seven days a week for months and we were still only able to help the smallest percentage of families in need.

4. With the issues in care homes so widespread, there was obviously a need for systemic and social change, so we also then began exploring solutions and campaigning to raise awareness of how brutal the system currently is.

5. In addition to highlighting the neglect of the elderly and those with special needs in care facilities during the Covid crisis, we wish to ensure that the appalling suffering and preventable deaths of our most vulnerable citizens in care homes have not been in vain. We wanted to help create a legacy of change by offering meaningful solutions to many of the problems besetting the care sector.

6. We operated entirely without funding, solely on the basis of pro bono work being undertaken by our founders and other involved family members. Almost all of our interactions were online and we provided one-to-one support and advocacy where we could in the worst cases, via phone, video and emails.

7. We also maintained a closed Facebook group of over 1000 members where we provided daily support and advice to a very wide group of families and provided online resources including legal information and template letters for families to use **(EXHIBIT PCW/04 – INQ000588698)**. In addition, for two years we ran weekly group zoom meetings of up to 15 people at a time

8. Additionally, we created a PCW website with support from Shape History to empower families, raise awareness and enable us to undertake surveys and the collection of stories from families. We also produced a short campaign video with the assistance of Shape History. The video is attached as an exhibit to this statement **(EXHIBIT PCW/21 – INQ000000000)**..

9. We connected and supported individuals and families across the country. The backgrounds of PCW families are as varied as the geographies they live in. Whilst all individuals support (or supported) a relative in a care or nursing home, the struggle they experienced cut through any difference in socioeconomic background. The amount of money paid to a care home seemed to make little difference to the challenges faced.

10. We were also active with the media; liaising with newspaper, TV and radio journalists and taking part in television interviews, including a live television interview with Social Care and Health Secretary Helen Whately on ITV. We wrote for The Guardian about issues surrounding care **(EXHIBIT PCW/01 – INQ000588695)** and presented evidence to MP's at the APPG Pandemic Response **(EXHIBIT PCW/02 – INQ000588696).**

11. As the People's Care Watchdog was set up spontaneously and informally, we had just two formal primary working partnerships. The first of these was with Shape History, a social impact

communications agency, who kindly worked pro bono with us to help us shape our early plans and produce a short campaign video. Our second and much more substantial partnership has been with Hodge, Jones and Allen who have very kindly given us a huge amount of pro bono legal expertise. Their Medical Negligence team also agreed to take on our families' cases, despite the obvious lack of commercial return. This allowed us to collectively explore whether the civil court system might enable us to secure some justice for care home residents and whether we might create some meaningful social change through case successes.

12. PCW hoped to support care home providers and involved health and social care professionals to work more positively with our families and their loved ones in care homes. We did this by offering friendly expertise in difficult areas and by offering a good practice sample visiting policy and visiting risk assessment **(EXHIBIT PCW/03 – INQ000588697).** Sadly, no matter how friendly and professional our approaches were, we found the system as closed and defensive as our individual families had when trying to resolve their issues. Core group members of the People's Care Watchdog wrote to and sometimes spoke with:

    - Social Services Managers and Directors
    - Public Health Directors
    - Care Quality Commission
    - Lots of care home providers
    - Advocacy services
    - Various MPs
    - Local Councillors
    - Information Commissioners Office
    - Social Work England

    Examples of our correspondence can be found at **EXHIBIT PCW/05 – INQ000588699).**

Summary Of Our Surveys, Research And Testimonies Collected About The Pandemic's Impact On Care Recipients

13. We have been collecting information on the impact of the crisis on care home residents and their families since our inception. This has been an inherent part of both our advocacy and campaigning work. Initially, we collected assessment information through one on one video and telephone meetings. Then we progressed to holding online group meetings, where we could collectively explore and understand what was happening in and around care homes during the

crisis. Between PCW's three co-founders, we have spoken in person and at considerable length with more than 100 care home families up and down the country.

14. PCW's co-founders also used the closed Facebook group to provide continual advice and support to care home families. This enabled us to undertake real time monitoring of the experiences of care home residents and their families across the country. We also ran numerous mini Facebook surveys, to better understand specific issues as they arose.

15. In addition, we launched a very ambitious multi-faceted survey **(EXHIBIT PCW/06 – INQ000588700)** to try and gather vital data relating to the experience of families with loved ones in care homes during Covid. This survey asked care home families for information relating to eleven different areas: Placement overview; Covid; Safeguarding; Deprivation of Liberty Orders, Psychiatric Medication; End of Life Care; Court of Protection; Advocacy Services, CQC; MPs and Councillors; and Family Members Health & Wellbeing. We had 105 survey respondents in total, although people only completed questions on the forms that were relevant to their loved one's experience.

16. We also collected written testimonials from approximately 100 families, some of which you can find in our exhibits **(PCW/07 – INQ000588701, PCW/08 – INQ000588702, PCW/09 – INQ000588703 and PCW/17 – INQ000588711)**. Given the nature of our organisation, the findings of all of our differing research efforts make up the bulk of the information we have presented in this document.

Our concerns in relation to the pre-pandemic structure and capacity of the care home sector

17. It is our view that it is only through understanding where we were before 2020 that we can understand what went so badly wrong during the Covid crisis. In the years running up to Covid, numerous academic studies, political and business reports, research, news articles and documentaries have described the ever-increasing failings and fragility of the care home sector. In fact, there has been so much understanding of this that it's hard to understand how action hasn't already been taken by successive administrations. There already was an urgent need to improve the circumstances of the thousands of our country's elders and most vulnerable long before the Covid crisis.

18. The British public, however, has very little idea about the scale of issues and suffering across our country's care homes, as well as the primary cause of such widespread failings. They would be

horrified to understand the levels of neglect and abuse that our most vulnerable have been subject to in care homes, even before Covid.

Pre-Pandemic Care Home Sector Overview

19. The British public has heard a lot about the increasingly impossible financial burden of caring for our ageing population; with well-known issues such as chronic understaffing and low wages all repeatedly blamed on underfunding by Government. However, the public are not widely aware that:
    - 94**% of care home beds (LaingBuisson, 2021) across the sector or 85% of care homes (CQC data 2023) are now owned and run primarily to make profit for investors**.
    - Profits from the UK's care home sector are generous enough that investment in the sector is heavily promoted by private equity companies to investors from around the world.
    - Private equity firms own three of our country's five biggest care home providers (PHA, 2023).
    - UK healthcare companies have become an even bigger target for private equity investors in the last few years, according to LangBuisson (2023), with 150 deals struck since 2021. (This is despite the facts that research clearly shows that this will only increase the fragility and failings of the care home sector.)

20. Private equity funds and their investors also want to see a return on their money in three to five years, or a maximum of seven years. Consequently, private equity companies often take drastic action to increase a company's value once they have acquired it, as do many privatised care homes **(Exhibit PCW/20 – INQ000588714)**. We can see the some of the impact of the inherent drive to reduce costs and increase profits in the following areas:

- **Care Quality**

21. For many years, research has shown that the most serious care delivery issues and almost all involuntary closures by the regulator happen in for-profit care homes. Since 2011, this has translated to 1 in 30 privately owned care homes receiving enforced closure orders, which, as researchers describe, are due to: *"Serious regulation and safety breaches... [and] most importantly, the neglect leading up to an enforced and acute closure can be traumatic and harmful for residents"*. (Oxford University, 2024). Furthermore, when laid bare, the daily decisions being made to maximise financial gains across the care home sector represent the systemic abuse of Britain's most vulnerable.

22. For example, prior to Covid, regular visitors to care homes could see that under-staffing wasn't just a problem, it was policy. Low staffing is a cost-saving built into the plans for profit driven homes. Particularly, in very large facilities built for efficiency, residents are often just left to wander aimlessly, with not enough staff to provide meaningful care. These homes can become like warehouses for Britain's elderly and most vulnerable citizens, who are seen by visiting families wandering aimlessly or laying alone in their beds often clearly suffering distress.

23. It is also usual for care home providers websites to show photos of delicious meals options that might be offered to residents while whistleblowing staff have explained that as little as £1.50 per day is actually spent per resident. Many families with a loved one in a care home will tell you about the very cheap food and drinks served every day. And, prior to Covid, it was usual for families to supplement poor quality or inappropriate diets (such as not providing prescribed high calorie diets or diabetic meals) with food brought from home.

24. Families can also attest to the fact of residents being left to stare at their plate of food or their drinks, completely unable to feed themselves and with no staff to assist them. There are hospital admissions across the country from care homes due to dehydration and / or malnourishment because even these most basic of care tasks are being neglected in criminally under-staffed facilities.

25. Furthermore, we know that many care home providers have policies in place that prevent staff from changing a resident's incontinence pad more than 3 or 4 times in any 24 hour period (whichever is the number of pads provided to the home free by NHS allocation.) Consequently, when families turned up unannounced during the Covid crisis, to see their loved one through a window, they would often not only see their loved one very unkempt but also showing visible incontinence issues, such as urine running down their legs.

26. It is also not unusual for large corporate care homes to make their staff sign a legally binding confidentiality agreement about conditions in the homes they work in. This fact alone speaks volumes about care home provision today, but this has yet to be addressed by regulators, commissioners or politicians.

- **Staff Recruitment, Training and Retention**

27. While there are many excellent carers, who are extremely dedicated, there are also many with no real calling for this demanding work. For many, caring is a job that is interchangeable with retail

and other unskilled work. If a carer has a natural aptitude for this work, then they will always demonstrate significant empathy, care and kindness. If they don’t have these qualities then vulnerable care home residents just represent tasks to complete. Dementia carers have been overheard, for example, describing their care job as easier than a previous one in the local bacon factory.

28. With private care home providers paying very low wages (minimum or just above) for this highly skilled and demanding job, there are excellent carers having to find other work to be able pay their bills.

29. Furthermore, providers are not only paying carers a minimum wage, they are also investing a minimum amount in training and support. Many families know well that their loved one’s care home has only offered staff basic mandatory training and that those training requirements are usually met through low cost e-learning courses. This type of training is not only inadequate for dealing with individuals with myriad complex needs but also fails to encourage carers to stay in their jobs.

30. There is also a historic issue with many staff not being able to meet the language and communication needs of residents. Good communication is vital for those with complex needs if anxiety, stress and behavioural issues are to be kept to a minimum. Limited English and/or communication skills restricts a carers ability to build relationships with residents and to communicate about tasks they are undertaking with them. If a carer simply repeats an instruction in a louder voice, as often happens, this doesn’t improve the ability of an individual with communication needs to understand it. However, it often does increase irritation, anxiety and isolation for the resident. These were all issues prior to Covid that were only magnified when visitors were locked out.

31. Whistle blowers from the industry have described at length how difficult it is to be a caring carer in a profit-focused facility. Couple their daily experiences with low pay, poor training and a lack of appreciation for the work they do,and it is little wonder that the sector struggles to retain carers and managers. All our families will attest to a rapid turnover of staff, and the over-reliance on agency workers that don’t know or understand residents’ history and needs. The consequences of all these staffing and training issues were then exacerbated during lockdowns as evidenced in our case studies and testimonials.

- **Cleaning, Hygiene and Infection Control**

32. It must also be noted that prior to the Covid crisis, whistle-blowing carers frequently described the strict rationing of gloves, aprons and cleaning materials to reduce costs in a home. This was also coupled with poor carers lacking appreciation for why good hygiene and infection control measures were required. Consequently, families frequently witnessed staff lacking the common sense and motivation to attend to the basic hygiene requirements of tasks, alongside homes having limited cleaning and hygiene materials for staff to use. These were not workplaces demonstrating the capacity to work with the serious infection control requirements of the Covid crisis.

- **Capacity to Safeguard Vulnerable Care Home Residents**

33. The abuse and neglect that has gone on in many care homes for years, and which increased so much during Covid, also reflects wider significant pre-pandemic capacity issues. In particular, the significantly reduced capacity of public bodies to safeguard vulnerable citizens.

34. With successive Governments implementing very hard austerity measures, local authorities have had to drastically cut back on services and huge amounts of critical public infrastructure has been lost. Things have become so difficult that many councils now struggle to meet their minimum legal obligations, including their duties to safeguard vulnerable adults.

35. Austerity measures have also impacted British policing, with ongoing cuts leading to such a reduction in police officers that numerous serious crimes are now not investigated. Police across the county are also now often unable to meet their Safeguarding duties. Consequently, an untold number of crimes in care homes are being ignored, allowing perpetrators to continue to commit serious crimes against the vulnerable.

36. Those in our cohort with medical and social care experience can also attest to the significant erosion of professional standards and expertise in British social work, healthcare and policing over the last few decades. There appears to have been a ‘dumbing down’ of our professions created by politically driven cultural shifts and policy decisions that prioritise cost-cutting across public services over people, ethics and even competence.

37. In addition, there have also been a number of significant failures to safeguard British citizens demonstrated by CQC and reported on since their inception. Famously, Panorama reported on several very abusive care settings that CQC had been involved with, or received safeguarding reports on, without them taking any action. An experience reflected by our cohort. CQC

themselves have also frequently admitted to varied operating issues and there have been a large number of complaints and issues raised about the regulator by numerous and varied organisations.

38. With all of these factors at play, professionals tasked with safeguarding care home residents simply didn't have the capacity to respond to all the risks citizens in care homes faced during the Covid crisis. As our case studies and family testimonies evidence, it is our country's elders and most vulnerable who have born the awful cost of the privatisation, dumbing down and under-resourcing that successive Governments have led over the last few decades.

Our Experience Of The Impact Of The Pandemic On Recipients Of Care

39. The response to the Covid crisis caused unparalleled collateral damage. From the cohort we were in touch with from 2020 onwards, we assert, and will illustrate, that it was the *response* to the crisis, not Covid itself, that caused the worst trauma, unnecessary deaths and untold suffering, still reverberating into lives in 2025.

40. We can show how the response to Covid did not limit physical and psychological risks to the most vulnerable, it increased them. Those who are older or disabled are more susceptible to the symptoms and possible complications of a virus or disease. However, it is very clear that those in care homes would have had a greater chance of survival had the Covid policies not been in place and if human rights and best practice had been upheld.

41. When combined, restrictions like the banning of family visits, the lack of in-person GP appointments, and the blanket implementation of non-consensual, Do Not Resuscitate (DNR) and Do Not Admit to hospital (DNA) orders, meant that care home residents were failed by Government, medical bodies, local authorities and many care providers.

42. In our experience in 2020, there was a concerted (and now documented) effort by government and media to stoke public fear and actively ignore all health conditions and risks other than Covid. The government funded media campaigns used 'Grandma', as the 'poster girl' for the public health measures, whilst failing to risk assess and respond to the biggest risks to this older age group. A search on the Office of National Statistics in November 2020 for causes of death showed that in June 2020, dementia was the biggest killer across the country followed by heart disease. More recent exploration on the ONS shows that during the first wave of covid in 2020, dementia and

Alzheimer's disease remained the leading cause of death among care home residents in England and Wales (PCW/24 – INQ000000000).

43. The impact of ‘locking down’ care homes was without precedent, without evidence base, and without a thorough risk assessment. For most of those in a locked down care home their decline was rapid, heart-breaking and unnecessary.

44. We will cover the following, experienced by care recipients during the Covid crisis: Psychological harms, Physical harms, Care Quality, Inequalities relating to ethnicity, age, disability, and nationality and Failings in Safeguarding

Psychological Harms

- **Isolation**

45. Both families and whistle-blowing carers, have told us about residents being isolated in their rooms for days and weeks on end, with absolutely minimal human contact. The psychological impact of being isolated, particularly from their families, was devastating to residents and completely overlooked by risk assessment.

46. It was impossible to explain to the elderly, particularly those with dementia, why they were being denied access to family and isolated. Nothing on this scale of disruption and sudden abandonment by all their loved ones had ever occurred. In the case of PM, Facetime conversation recordings demonstrate her mother’s distress increasing as she blamed herself for being in ‘prison’ and not understanding how this had happened **(EXHIBIT PCW/08 – INQ000588702).**

47. Also, by isolating care home residents from family, a vital layer of care stopped. Family members were no longer able to help with vital day-to-day tasks including personal care and meal times. Natural safeguarding checks that come with regular family visits also ceased.

- **Cognitive and emotional decline**

48. All families within our group observed (through window visits or video calls) a rapid and increased cognitive and emotional decline in those who were locked in care homes. It is estimated that 70% of people in care homes have dementia (Alzheimer’s Society). Across the board, families saw dementia symptoms worsen with increased confusion, agitation and withdrawal, as well as a

marked decline in ability to communicate. In this depressed state residents were also less inclined to eat and drink, creating a downward spiral of deterioration.

49. DG's mother was 95 when she was on a 'locked landing' for a year. Three Best Interest Meetings were held that failed to meet the requirements of the Mental Capacity Act in numerous ways and DG's mother continued to be deprived fresh air, sunlight and the support of her son. This had a detrimental impact on her dementia, as well as a marked effect on her son's mental health **(EXHIBIT PCW/09 – INQ000588703).**

- **Window visits, video calls and garden visits.**

50. The impact of families having to witness loved ones' rapid decline from the other side of a window or a camera was torturous. The window visits were rarely without stress, upset and emotion. Those with (and without) dementia would frequently reach out from behind a window, clearly very distressed by the separation and isolation.

51. Video contact by family was only possible when residents had access to phones/iPads in their rooms and a staff member was available to assist. When calls were attempted, they often proved inadequate or were simply disturbing for the residents. An elderly person with dementia doesn't understand how to use a screen to communicate through. Often, they couldn't focus on the screen, were confused as to where the voice was coming from or tried to kiss the iPad screen.

52. Some care homes didn't have facilities for window visits and organised garden visits, which were often not viable because of unpredictable, cold and wet weather that would cause frail residents discomfort and risk. Sheds or unoccupied garden bedrooms were sometimes used as a visiting space and were also often much too cold for a frail elderly person. The use of perspex screens dividing visitor and resident created a formal and confusing interview setting and often looked and felt distressingly like a prison visit. In some cases, microphones were used to communicate through the screens which brought distortion to voices and another layer of alienation and confusion for residents.

53. PM's mother, was very anxious in the visiting room (an unoccupied garden bedroom) because she thought a resident would return to it at any time. She also believed that the distance and lack of physical contact between her and Patricia was because something serious had happened in their relationship. To be so close, but not to be able to hold hands or hug, was too damaging an

experience for both of them to repeat a second time. Numerous families felt the same **(EXHIBIT PCW/08 – INQ000588702).**

54. Through window visits, video calls and garden visits, relatives observed bruises from falls, dirty clothes, weight loss, incontinence issues, dehydration and in one case a sexual assault and yet were powerless in protecting their loved one. Concerns were too frequently brushed off with no meaningful action taken.

- **Impact on relatives and staff**

55. When considering psychological impact and mental health, it is important to highlight that it was not only the residents in care settings that suffered.

56. All relatives we have spoken to have mentioned their own mental health decline. Five years later the majority of people we speak to who had relatives in a care home are still plagued by nightmares, daily flash-backs, anxiety, rage, depression, and insomnia.

57. In the worst example of this, one of our members took her own life. Lucy* was a mother of four children, the youngest were teenagers at the time. During lockdown Lucy had managed to remove her grandmother from a failing care home where she had safeguarding concerns.

58. By all accounts Lucy had brought her grandmother ‘back to life’ with homemade food, regular treatment to her damaged skin and loving, familiar conversation. Lucy had also found a much better, local care home and was in the process of organising the transfer. However, the original care home put a false complaint into Social Services. This accompanied with Social Services misunderstanding of due legal process in relation to DoLS (Deprivation of Liberty), led to a large amount of pressure directed at Lucy.

59. The feeling of harassment by social services, combined with the fear and shame used by media and government to comply with draconian measures, made her fear she’d be sent to prison. A great lover of the outdoors, she couldn’t bear this threat and chose to take her life instead. (*Name changed for anonymity.)

60. Staff members of care homes also suffered psychological harms. They were thrust into a situation they were practically, professionally and emotionally unequipped for. Whistle-blowers have put on record the lack of support and resources from management and owners – including refusal to increase staffing levels, refusal to stop accepting Covid active patients from hospitals despite homes being woefully unequipped to manage the infection, and the ongoing rationing of PPE to save costs. Unable to offer adequate care or facilitate medical support to residents meant that many good carers were left to powerlessly watch someone suffer and often die. Many carers became too traumatised to return to work.

61. The psychological impact of lock down policies on residents, families and staff cannot be underestimated. The traumatic experience of lock down has not gone away. It has taken significant psychological resilience for all contributors to this submission to gather information and re-live this dark period.

Physical Harms

- **Impact of No GP Visits**

62. Our families' and whistle-blowers evidence that the majority of care homes did not have any GP visits for extended periods of time, in some cases up to several years.

63. Care staff, who are not medically trained, were placed under immense pressure having to tend to vulnerable and or sick people without any medication or medical support. They were also relied upon to give information to GPs over the telephone or video call. Within our cohort we have examples of significant symptoms and physical changes being observed incorrectly or being missed completely. When information given to a GP is not detailed or relevant, there are life or death consequences.

64. Without the opportunity to perform a physical examination of the patient, it is extremely challenging for GPs to accurately assess a patient's condition and recommend appropriate treatment, all the more so with patients lacking capacity. When one considers that around 70% of care home residents have some form of cognitive impairment, the scope for error was huge. While it may have been appropriate for residents with capacity, remote consultation was wholly inappropriate for residents suffering cognitive impairment. In addition, families have told us that care staff had left residents with dementia and other cognitive impairments alone in front of the screen and walked off, leaving them unsupported.

65. The risks presented by remote access protocols during the Covid period were not limited to residents with dementia. Most residents would have had difficulty describing their symptoms accurately over the phone or video call. Most of those living in care homes are hard of hearing, have failing eyesight, or suffer other communication barriers, leading to misunderstandings or incomplete information being relayed. Those with complex pre-existing conditions were most at risk, as were those with urgent symptoms that needed prompt intervention and regular follow-up.

66. Given the limited availability of remote consultations, and the fact it was care workers, not families, who were largely responsible for raising medical concerns with surgeries and arranging online consultations, calls often focused only on the ‘problem at hand’. We have numerous reports of care staff reporting only the issues that were of concern to them, usually behavioural issues due to all that was happening during Covid, rather than primary physical health issues, which were repeatedly missed.

67. For example, a resident with who had been prescribed the benzodiazepine Lorazepam for ‘agitation’ in late 2019, had not received a medication review in almost two years despite numerous telephone consultations over the period. It was not until the daughter, AH who was unaware the prescription had continued, raised concerns on finding her malnourished and emaciated mother “almost comatose” on three consecutive weekly visits, that the medication was stopped.

68. AH’s mother was still being administered the same dose of lorazepam as had initially been prescribed two years earlier, despite the fact that the dose should be regularly reviewed and not continued for more than six months, and despite the fact that her mother had lost over half her body weight in less than a year. AH had been told that the weight loss was due to her mother’s poor appetite, and that this was a symptom of her condition (Alzheimer’s).

69. The truth was that she was so heavily sedated, and so poorly supported when she was awake, that she was unable to eat. The lady was so malnourished and weakened that her health rapidly deteriorated. She had a series of infections over this time and in her last week at the home, the daughter was informed that it was unlikely she would survive the week. However, in fact, once she

had been taken off the drug, she was more alert, willing to eat, and began to put on weight. She then lived for a further two years.

70. Given restrictions on family visits to care homes, there were no relatives able to participate in care home remote GP consultations, leading to a lack of communication and understanding of the resident's needs. Communication between care homes and families was poor at best, and in many cases known to us, wholly inadequate. Families told us there was often very little pro-active communication from care staff alerting them when their loved ones were ill, and virtually none from GP surgeries, who preferred to communicate with care homes.

71. Even family members holding Lasting Power of Attorney for Health and Welfare and, therefore, decision-making powers over care and treatment decisions describe lack of both consultation and even ongoing information. If online consultations were carried out, families were seldom informed or notified of any treatment decisions. Worried and concerned families spoke of unanswered emails, of telephones going unanswered for hours, sometimes days. Those who did finally get through, told us of fractious conversations with care staff too busy to engage, or GP receptionists unable to provide any meaningful information and reluctant to transfer calls to the GP concerned.

72. AH who held Lasting Power of Attorney for Health and Welfare, and had played an active role in treatment decisions previously, told us how over-the-counter medications she had sought the GPs approval for previously and which had helped calm her mother during personal care, were left untouched and instead Lorazepam (a benzodiazepine) had been prescribed without any consultation with the family. She also discovered on reading her mother’s medical notes following her death, that she had been prescribed several anti-psychotic medications, again without her knowledge.

73. The lack of GP visits not only impacted the demands placed on carers and the health of those living in care homes, it also impacted the registering of deaths. After the death of a close friend in PM’s mother’s care home, the Registrar at the Coroner’s office stated that due to no GPs visits to ascertain cause of death, all care home deaths were being attributed to Covid. This ruling would inflate the number of deaths attributed to Covid whilst minimizing the understanding and data of other causes of death **(EXHIBIT PCW/08 – INQ000588702).**

74. Alongside, GP visits being stopped, many other crucial healthcare visits from professionals ranging from Tissue Viability Nurses to chiropodists were stopped. Even stopping a service as simple as Chiropody can have far-reaching consequences in a care home because care staff are usually instructed not to cut nails in case of complications. Therefore, residents were just left to suffer horribly long nails, which were very painful and could quickly lead to further medical and behavioural issues **(EXHIBIT PCW/10 – INQ000588704).**

Neglect

75. Due to isolation, no visits from family, restricted access to GPs, low staffing levels and inadequate quality of care, we are capturing one of the major overall physical harms our cohort experienced under the umbrella of 'neglect'. We have divided this topic into the headings below.

- **Malnutrition and Dehydration**

76. As mentioned at paragraphs 25 and 26 above, there are historic issues with insufficient food and fluid intake in numerous care homes but this became far worse during lock downs.

77. Without family visiting and supporting them, residents in care homes who couldn't feed themselves rapidly deteriorated. Staffing levels are historically inadequate to meet the lengthy time it takes to feed someone with complex needs including dementia. Without family visits, there was nobody to assist with ensuring residents were eating and hydrated. Consequently, weight loss was noted across our cohort, including in the cases of VG and TT . By the time VG's family re-gained entry, she had lost 25kg (despite having a written dietary plan due to previous weight loss concerns) and was skeletal. TT was also emaciated by the time her family managed to get her out of the care home.

78. Dehydration was also an issue. it was common practice before the Covid crisis for drinks to be just left with residents who were unable to pick them up. Again, this neglect accelerated during lockdowns, creating a knock-on effect of other issues including constipation, urine infections and increased agitation and delirium. DC's Mother was admitted to hospital with dehydration from pre-noted lack of carer input with food and drinks. The kidney damage she suffered as a result of dehydration led to her death in hospital a week later **(EXHIBIT PCW/17 – INQ000588711).**

79. PM reported her mother was regularly dehydrated which contributed to constipation. The problem was exacerbated by overheating in her room which was habitually at 80 degrees due to faulty heating system that was never repaired. PM's reporting of concerns to management and eventually to Kensington and Chelsea Council, met with no meaningful response **(EXHIBIT PCW/12 – INQ000588706).**

80. Many families who submitted evidence to us, shared care home fluid charts and other records attesting to dangerously low fluid intake. Others shared distressing photographs of gaunt, severely dehydrated relatives gasping for drink, and "looking like death", others gave accounts of their battles care home staff who refused to raise concerns with GPs. Some families were so concerned by the condition of their loved one and by the care staffs' unwillingness to do anything, that they simply called ambulances themselves**.**

- **Incontinence, clothing and appearance**

81. Much neglect was witnessed through window visits. It is very distressing to see your once proud, elegant relative in the following state:

- Dressed in other people's clothes which do not fit them and restrict circulation
- Wearing dirty clothes
- In visibly wet incontinence pads
- Bruised or wounded
- Unshaven and unwashed

82. ED went daily to check her mother's welfare through the care home window and was also horrified at the visible signs of neglect that included dirty clothes, a runny nose and her mother regularly in a wet incontinence pad with urine running down her legs. The care home never responded to her raising concerns with them and eventually ED's mother was in such a poor condition that ED called an ambulance. They immediately transferred her mother to hospital, where she died a week later from the terrible infection in her legs **(EXHIBIT PCW/09 – INQ000588703)**.

83. AS's mother was bruised and bloody when the family saw her through the window. After a fall, no one in the care home had cleaned her up and no doctor had been called to check her injuries.

The family watched from the window as she walked around in a confused, bruised and very distressed state and the home still wouldn't allow any of them to check or comfort her, despite no one in the home even being able to speak her language **(EXHIBIT PCW/09 – INQ000588703).**

84. After Facetime calls PM reported that her mother's fingernails were caked with what appeared to be faeces **(EXHIBIT PCW/11 – INQ000588705).** She also recorded unexplained and unreported bruising on her mother's face, arms and legs. The majority of our families had similar experiences witnessing the neglect, injuries, ill-fitting clothes and numerous other indicators of a lack of care.

- **Untreated Urinary Tract Infections**

85. Many care home residents either suffer from urinary incontinence and / or have been put in incontinence pads or have catheters because this is easier for the home to manage than toileting routines. Both increase the risk of infection significantly, most particularly in the case of catheterisation. Given the impact of staffing shortages on the frequency of care checks and interventions during the Covid crisis, catheter bags were often left not emptied or not adequately cleaned, and residents were left for hours in sodden pads, further elevating risk of UTI infection, especially among the bed-ridden and those with reduced mobility.

86. *"Mum was often severely dehydrated and suffering from delirium when I visited. I had to call the surgery on a number of occasions to insist on a urine test as staff never had any "concerns". On no fewer than three occasions, it turned out she had a UTI, as I had suspected." I hate to think how she would have fared if I hadn't been able to advocate on her behalf and ensure she got the antibiotics needed to fight these infections."*

87. Many care home residents and hospital patients were less fortunate. Families denied visiting access were unable able to support, monitor, and ensure their loved ones received the antibiotics they needed. If left untreated, urinary tract infections lead to delirium, deteriorating health and an increased risk of both blood stream infection and all cause mortality. The risk of mortality arising from untreated UTIs is also significantly higher among the over 65s, most particularly among those living in residential care settings where hygiene control is often poor, where deteriorating health is not always effectively monitored, and where delays in diagnosis and treatment are common even during normal times.

88. With families locked out and unable to monitor and advocate for their relatives, and with overworked staff struggling to provide even the most basic care support, common signs and symptoms of urinary tract infection were simply and very frequently overlooked by care homes while families were shut out.

- **Pressure sores and skin ulcers**

89. A single pressure sore is considered a safeguarding incident. Unfortunately, during lock downs, numbers and severity of pressure sores increased for our cohort.

90. After fighting for several months to gain access to her relative, FG found her with six, grade 4 (the most serious) pressure sores, several which went through to sinew and bone. No pain relief had been prescribed and the nursing home had not contacted the Tissue Viability Nurse. The home had also repeatedly told the family on the phone that everything was fine **(EXHIBIT PCW/09 – INQ000588703).**

91. ED raised countless concerns with the care home about the deterioration she was witnessing in her mother. She resorted to calling an ambulance in March 2021. The ambulance drivers said they could smell infection before entering the room. The skin on her mother's legs was ulcerated and so badly infected that she died 7 days later in hospital **(EXHIBIT PCW/09 – INQ000588703)**.

92. TT had two pressure sores from sitting in a chair all day for weeks. Her family were not informed and found out by accident through an open window from a staff member. TT was then bed bound and isolated in her room for two weeks in an attempt to heal her skin **(EXHIBIT PCW/14 – INQ000588708)**.

- **No access to medication or medical care**

93. Access to medication and medical care was limited due to no in-person GP visits and also DNA (Do Not Admit to Hospital). In a Freedom of Information request to CQC, it was stated that half of

those who died in care homes were not offered any medical support **(EXHIBIT PCW/13 – INQ000588707**). Whistle-blowing carers are on record stating the trauma of having to witness residents' rapid deterioration, without being offered oxygen or medication. How many of those of died would have survived with medical care will never be known.

94. When care home residents were taken to hospital it was still a battle. In TT's case she ended up being transferred to A&E due to unexplained vomiting and a suspected stomach bleed. The A&E doctor who spoke to TT's daughter on the phone did not wish to proceed with any investigation or treatment due to TT's 'frailty'. TT's daughter, a retired nurse, had to request multiple times that her mother receive an x-ray and fluids. Significantly the x-ray revealed an impacted bowel i.e. constipation (lethal for older people), which had resulted in TT vomiting feces. With appropriate treatment of intravenous fluids, enemas and medication, she made a full recovery. The limited access to medical care is further covered below under 'fragility' **(EXHIBIT PCW/14 – INQ000588708)**.

95. Following a Facetime call, PM noticed that her mother, wasn't moving her right arm. Concerned it was a stroke, she reported it. It was confirmed that the arm was in fact injured, and the GP had requested an X-ray. PM spoke to a physio who advised that from the description given, it was likely a ruptured tendon which could only be diagnosed by an Ultrasound scan not an X-ray. PM liaised with the GP and Management and, after a significant time of chasing was told she could collect her mother from the Care Home and take her for a scan, if arranged and paid privately. The scan confirmed a fully ruptured tendon. This incident led to a Safeguarding Investigation **(EXHIBIT PCW/08 – INQ000588702).**

96. PM and her mother's experience above illustrates not only a missed injury and misdiagnosis but also that the scan needed was only available if advocated strongly for by a relative and organised and paid for privately.

- **Maladministration of medication**

97. We also wish to note the maladministration of medication. End of life pathways and the drugs involved are covered fully below. However, families and whistle-blowing staff reported the

increased administration of anti-psychotics (almost entirely contra-indicated for the elderly and those with dementia), during the Covid crisis.

98. GD's father was prescribed an anti-psychotic that guidelines are clear should never have been given to him or any elderly person with dementia. This anti-psychotic is also known to cause low potassium levels, which her father had previously been diagnosed with, and when his levels again dropped his daughter was discouraged from pursuing outpatient treatment for him. Then, after her father had eaten his lunch he was inexplicably started on an end of life pathway in the care home, where he died 24 hours later **(EXHIBIT PCW/09 – INQ000588703).**

99. The huge stress that care home residents of all ages were placed under, including isolation and separation from loved ones and often being confined to bedrooms for weeks on end will have induced a very understandable range of behavioural difficulties and depression. However, care homes frequently responded to this by simply ringing the home's GP (many of whom are being paid retainers by the care home provider) who would prescribe contraindicated antidepressants and anti-psychotics to simply sedate the resident.

Care Quality

- **Low staffing levels**

100. By locking down care homes, the family support that was relied upon by all the understaffed care homes disappeared overnight. The contribution made by family members was not recognised prior to Covid, nor was it considered when the decision was taken to close care homes doors, leaving residents without vital care support. This support provided by families includes the following:

- the regular moving of position to ensures pressure sores do not develop
- the regular changing of incontinence pads for comfort, dignity and skin integrity
- assisting with feeding to maintain healthy calorie intake
- assisting with drinking to stay hydrated
- human connection, companionship and very important reassurance, as dementia is often very frightening disease for sufferers

101.PM has email evidence reporting of dangerously low staffing levels. She also contacted CQC to inform of this and asked that they undertake an unannounced visit to the home and that they don't let the Manager know that it was her that reported them, as like all our families she was worried about the consequences. CQC ignored both of her requests and on the day of the inspection, the care home simply ensured that extra staff were brought in **(EXHIBIT PCW/08 – INQ000588702).**

102.Once the Track and Trace initiative was brought in, staffing levels were simply reduced further. People were then required to stay off work even when not displaying symptoms and testing negative for infection.

- **Communication**

103.During lockdown the only real source of conversation for residents came from carers. Many carers speak basic English or have inadequate communication skills. Lockdowns left many residents desperate for conversation, connection and reassurance.

104.There were also failures in communication with families, even when it came to notifying families of serious changes or deteriorations in health, such as the development of pressure sores, as well as the prescribing of new medication or the withdrawal of regular medication.

105.In 2020 everyone found themselves in a completely novel situation with stresses and concerns on all sides. However, we would like to note a worrying trend that was observed by many of our members. Care home staff suddenly found themselves in elevated positions of responsibility and authority. Whilst this new status was embraced with grace by some, others often wielded this new authority inappropriately and aggressively under the guise of 'infection control'. It appeared to many in our group that the lockdown policies increased abusive tendencies within care settings or shone a light on those already present.

Inequalities Relating to Ethnicity, Age, Disability, and Nationality

- **Ethnicity and Nationality**

106.All individuals with dementia will lose second languages that they have acquired as the disease progresses. These language shortfalls were, being mitigated as far as was possible by families prior to the Covid crisis. When families were banned from care homes the vast majority of residents who were no longer able to speak English were left horribly isolated and additionally frightened by the language barrier. Families are also most often also the only people who recognise a resident's cultural and religious needs and this too was lost when families were banned from care homes.

107.Not one staff member could communicate with AS's Mum when she no longer understood English. Similarly, no effort was made to meet her religious or cultural needs, which had been met by her family prior to visiting restrictions. Despite this, it took nine months for the care home to even arrange a video call with her family. After his mother fell and was left in an appalling state and without any medical care at all, AS started the process of trying to bring his mother home. Even being made aware of all the issues at the home, Social Services incorrectly told AS he would need to get a Court order to end the DoLS order and bring his mother home. After trying to get help for various five months, AS found PCW and we explained the correct legal situation to him and Social Services. Three days later AS's mother was finally returned to the loving care of her family **(EXHIBIT PCW/09 – INQ000588703)**.

108.TT had also reverted to her mother tongue of Italian. No one in the care home was able to communicate with her and her daughter offered to work as a nurse for free within the care home to support her mother and provide medical support for all other residents. However, the care home owner simply refused to allow her in and there were absolutely no efforts made to meet TT's language needs. Her family were also excluded from the DoLS assessment and this was unlawfully carried out in English **(EXHIBIT PCW/14 – INQ000588708)**.

- **Age**

109.The NHS Frailty score can stack the odds against you if you're older or showing signs of frailty. If implemented strictly as an assessment tool it can mean you are faced with a fight for simple medical treatment. This was the case when TT was admitted from a care home into hospital **(EXHIBIT PCW/14 – INQ000588708 and EXHIBIT PCW/19 – INQ000588713**).

110.JB’s mother was in a care home and diagnosed by her GP as suffering from severe constipation. He recommended hospital treatment. When JB returned to the hospital the next day she found her mother had been connected to a syringe driver of Midazolam. Her mother had dementia and had nothing to eat and drink for many hours so JB was shocked by the sudden commencement of an end of life drug due to ‘delirium’. JB immediately took her mother out of the hospital and back to the care home. Her GP was equally shocked at what had taken place.

- **Disability**

111.It wasn’t only the elderly who suffered in care homes during lock downs. Younger people with complex needs also were subjected to a huge amount of inhumane treatment.

112.Suffering from Huntingdons disease, S was a young man in a care home. When his mother was able to regain access after lock downs she found him slumped in a chair, without socks on and not his usual self. He had been given anti-psychotic medication which in his mother’s opinion was used as a ‘chemical cosh which took away the very essence of him.’

113.G had learning disabilities and lived in a care home. He was repeatedly denied access to his mother and sister to whom he was very close, and his family knew that for months and months he was simply being wheeled in front of a window and left there every day for hours on end. His family approached PCW for help gaining access and we were shocked at the level of abuse and neglect that it became G was suffering behind the locked doors of the care home.

Safeguarding

114.Although the scale of the suffering in care homes during Covid will never be known, it is clear that a vast amount of very harrowing abuse and neglect went on up across the country behind doors that had been closed by Covid visiting policies.

115.Covid policies themselves often met the criteria for safeguarding classification, as psychological/emotional abuse or institutional abuse. However, aside from these issues, we received endless reports from our families of the serious abuse and/or neglect of their loved ones in care homes. We also know that, for most of the abuse and neglect cases that families told us about, other residents in that home would be suffering similarly. These harrowing examples from our families speak for themselves.

116. With each of these cases, the safeguarding issue in the care home was compounded by failures in the Safeguarding work undertaken by Social Services departments, who clearly colluded with the care home. When PCW became involved in our families' safeguarding referrals, we also usually involved Social Services Directors and local Councillors, but we were very concerned to discover that this changed little.

117. We also know that for every safeguarding alert that PCW raised that was ignored or found in favour of the provider, despite clear and compelling professionally checked evidence, vulnerable adults across that local authority would be being failed by their Social Services Safeguarding service.

118. The Covid crisis was not responsible for the safeguarding systems failures that were evident going into the crisis. However, the vastly increased level of abuse and neglect that went on behind the closed doors of care homes during the Covid crisis was a direct result of Covid policy of repeatedly banning families and professionals from visiting care homes.

119. We are, therefore, asking the Inquiry to recognise and acknowledge the vast amount of abuse and neglect that our country's most vulnerable not only endured during the crisis but also, in many cases, continue to endure today.

120. Furthermore, almost no one has been held to account for most of the abuse and neglect that went on, or the gross safeguarding failures and collusion that has enabled perpetrators to continue working with our most vulnerable citizens.

Our Views on Changes to the Regulatory Regime During the Covid Crisis

121. The shortcomings of the Care Quality Commission ("CQC) have been extensively documented and publicly reported since its inception. Successive governments have been made fully aware of the organisation's persistent operational issues over many years. It is also an obvious fact that the care home sector would not be in the state it is in if the industry had effective regulation. Therefore, it is unsurprising that our care home families were unanimously clear about the regulator's failings from their first-hand experiences.

122.On 16th March 2020, CQC announced that it would stop inspecting care homes and they gave two reasons for this decision. Firstly, they claimed that this would help to reduce the spread of infection, with no apparent consideration of the multitude of other risks care home residents would face in this scenario. The decision also wasn't clinically warranted. Given the crucial role CQC should play in the sector, visits should only have been put on hold for as long as it took them to establish effective infection control visiting procedures.

123.The second reason that CQC gave for their decision was that it would reduce pressure on providers. However, given how vulnerable care home residents are and how many care homes have recognised operating and safety issues, CQC should have fulfilled their duty of care to vulnerable citizens by replacing normal scheduled inspections with informal support and safety-check visits.

124.However, on 16th March CQC did state that they would still visit: *"in a very small number of cases when we have concerns of harm, such as allegations of abuse."* In addition, in May 2020 CQC rolled out its Emergency Support Framework, which they claimed: "*is a further source of intelligence that we are using to monitor risk, identify where providers may need extra support to respond to emerging issues, and ensure they are delivering safe care which protects people's human rights."*

125.However, in reality, our families repeatedly found CQC unwilling to take any action at all even when very serious cases of abuse and neglect were reported to them. Sometimes CQC appeared to show interest but then they never took any action. In other cases CQC told families that they didn't get involved in complaints about the treatment of an individual and stuck to this even when it was clear that all residents in a care home were at likely risk of neglect and abuse.

126.The experience that families had when trying to report serious concerns to CQC was also mirrored by the whistle-blowing care staff, who rang the CQC hotline in significant numbers to report concerns. However, these reports too were simply ignored. We cannot stress strongly enough how absolutely shameful CQC's behaviour was during the crisis.

127.Not only did CQC not respond to even very serious cases of abuse and neglect when they were reported to them, we can also evidence them clearly covering up awful safeguarding issues when they later conducted inspections of care homes our families had reported to them. Furthermore, we assert that this is a systemic organisational issue, as complaints about this issue were also covered up.

128.For example, VG was found with appalling pressure sores, several the size of saucers with bone visible through the wounds, and yet no urgent treatment had been taken to address these. The Tissue Viability Nurses weren't contacted, despite being previously involved, and, horrifically, despite, VG having these deep wounds for months which would have been excruciating, no pain relief other than paracetamol was ever given. This was such a serious matter that it was referred to the Police. We also ensured that CQC were given a comprehensive dossier clearly evidencing Wilful Neglect by the care home.

129.CQC refused to take any action at all in relation to this matter but they did have a routine inspection planned at the home just a few weeks later. However, despite making sure that the Inspector was aware of all that VG had suffered for months, while visiting was banned, CQC ignored the information provided completely. Instead, their report brazenly and falsely claimed instead that families were happy with the care provided and they increased the care home's rating from Adequate to Good. A comprehensive written complaint was then made to CQC about this cover up and their response was again inadequate.

130.PCW also had other families reporting the same upgrading of a care home's rating within weeks of them reporting serious abuse or neglect in that home. Consequently, we spent some time trying to understand why the regulator might be so determined to improve the ratings of care homes even in the face of appalling safeguarding reports. What we discovered was that CQC was measuring its own performance as an organisation partially by the apparent improvements care homes were showing. They were it seems, therefore, invested in finding improvements in care homes, even in the direst of circumstances.

131.CQC so grossly and knowingly failed in their duty of care to thousands of care home residents during the crisis that the facts describe criminal negligence. CQC could, therefore, actually be investigated for the corporate crime of Wilful Neglect. We are, therefore, respectfully asking the

Inquiry to treat this matter with the utmost seriousness and to consider what action might be an appropriate response to the reporting of these issues.

Our Views On Decisions, Communication And Guidance From The UK Government During The Pandemic

132. We recognise that overall Government has responsibility for the way in which the crisis was managed. However, we also recognise that this Inquiry seeks to ensure that the country and the care sector are better able to respond to any future crisis.

133. For this reason, we feel it is incredibly important to also draw attention to the huge failings of local Councils and other statutory bodies that were, arguably, much more responsible than central Government for the suffering and legal abuses inflicted on our most vulnerable citizens. Those bodies remain unaccountable to this day for their very significant part in all that went so horribly wrong across the care home sector. As a result, the Covid crisis has created a legacy of unlawful practices that continue to this day across the country and these issues now require the urgent attention of our elected representatives.

Hospital Discharge Policy

134. Although many poor decisions were made by Government during the Covid crisis, many of these should have been mitigated by responses from mature and competent professionals across health and social care, as we believe would have happened if the country had faced a similar crisis 30 years ago.

135. We would point out that the Government did not actually decide to discharge even one patient from hospital to a care home without a Covid test. In fact, all discharge decisions were made by a responsible clinician and the Government's hospital discharge policy stated the expectation that: *"Where applicable to the patient, COVID-19 test results are included in documentation that accompanies the person on discharge."*

136. The discharge policy also stated the expectation that: *"Senior clinical staff to be available to support ward and discharge staff with appropriate risk-taking and clinical advice arrangements."* So Government clearly and appropriately stated that senior clinicians needed to be responsible for decision-making around discharges. Therefore, if there were impacting issues, such as not

enough available Covid tests, clinicians should have delayed any discharges that were likely to be unsafe.

137. We don't dispute that some clinicians felt pressure to discharge patients as quickly as possible; but ultimately the decision to discharge patients appropriately remained with the responsible clinicians and those clinicians have to make difficult but professionally justifiable decisions every day.

138. It should also be pointed out that various epidemiological studies, including a comprehensive review published in The Lancet in February 2022, show that hospital discharges were actually not strongly correlated with Covid outbreaks in care homes. In fact, larger care home size was much more strongly correlated with Covid outbreaks than hospital discharges.

Care Home Visiting

139. It seems that Covid in care homes was most often 'brought in' from the community and the Government of the time could argue that this provides retrospective evidence for their policy of stopping care home visiting by families and professionals. We can also appreciate why for the first couple of months, in the first wave of Covid, this might have seemed like a reasonable idea. However, this would only be justifiable, legal and effective if all care home staff remained on the care home premises, throughout this time, without returning to their families and the wider community at all.

140. Although we know and appreciate that some very dedicated care home staff did take this decision early on, we know that this wasn't true for most care homes and not after the first wave of Covid. With staff in care homes coming and going daily and even working across different care homes, there was absolutely no lawful or clinical justification for the varied visiting bans that were imposed. (This fact is supported by the previously mentioned epidemiological review, which clearly identified shared clusters between different care homes, linked by shared staff or agency workers.)

141. When the Government of the time was challenged about the illegality of their care home visiting bans, they explained that they were prioritising Article 2, the absolute right to life, over the

qualified Article 8 right. However, this simplistic statement merely demonstrates a lack of relevant expertise on the part of the Government's legal and social care advisors.

142. While it is true that Article 8 is not an 'absolute' right, the law is very clear that qualified rights can only be interfered with if the interference can be shown to be 'necessary, lawful and proportionate'. The visiting bans simply could not be argued to be proportionate or necessary when they were only applied to some of the people entering the care home and particularly set against the extremely widespread and very serious harms that were always going to be caused by such bans.

143. A decision as serious and harmful as the visiting bans would only be proportionate and necessary if it offered some likely guarantee of infection never entering the home, which the visiting bans were never going to be able to achieve, unless they banned absolutely all foot traffic in and out of the homes. Covid only required one member of staff to carry the infection in from the community and it swept relatively quickly through a care home. A partial ban on foot traffic in and out of the home could not, therefore, come close to stopping any outbreak from occurring. The visiting bans could also not be considered proportionate when viewed against the wider extremely serious harms and suffering that they created, which could and should have been foreseen by the risk management work that should have preceded this policy being agreed.

144. The visiting bans additionally breached the 'lawful' requirement when their implementation also so clearly breached the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

145. Nevertheless, from July 2020, the Government handed decision-making about visiting policies to involved professionals, including Directors of Public Health who were given the lead role in each area, and care home providers. They also set out expectations that described expected good practice, such as the need for dynamic risk assessments to be undertaken and the need for providers to be mindful of the Mental Capacity Act.

146. Unfortunately, it seems that many involved health and social care professionals no longer have the knowledge required to undertake comprehensive risk management work. It is also our experience that many no longer know or care about the legislation in place to protect our vulnerable citizens.

Wider Law Breaking

147. Perhaps central Government failed to be clear enough in their guidance about their expectations around the law. However, we should be able to expect that professionals who have to use specific pieces of legislation every day in their working lives are actually conversant in it. Instead, we saw local councils and other statutory bodies up and down the country endlessly breaking the law, as well as colluding with care home providers who were also grossly breaking the law and causing untold serious harm to their residents by doing so.

148. It is easy to see in our testimonial evidence the terrible cost to care home residents and hospital patients of the key legislation that is in place to protect them, being broken. All of our families are able to describe in detail the anguish, despair, abuse and neglect that went on behind illegally closed doors. They also talk of the preventable deaths and of the many vulnerable adults left to die alone. If the applicable laws had been upheld a huge amount of suffering, injury and so many deaths would have been avoided. We cannot stress this one fact strongly enough.

149. The letters we wrote on behalf of families **(EXHIBIT PCW/15 – INQ000588709)** reminded statutory bodies of their legal responsibilities under the Human Rights Act, Mental Capacity Act and DoLS. The letters explained where workers and policies were very clearly breaking the law and described the grave cost to residents and families of this illegality. We also offered many care homes a sample visiting policy and visiting risk assessment, so they could easily ensure that they stayed within the law and that all likely risks would be assessed and responded to.

150. Most of our letters were sent to senior professionals, including both Social Services Directors and Public Health Directors, as well as to locally elected representatives. However, although we carefully worded every letter to be professional, clearly explanatory and helpful, Social Services Directors and local Councillors in particular often chose to simply ignore the facts of their departments overtly breaking the law. This reflects how broken British society has become. Numerous senior public officials, local councils, health and social care professionals and care home providers no longer care or worry about whether they and those they are responsible for are breaking the law.

Failures to Uphold the Mental Capacity Act (2005)

151. Furthermore, the legal breaches we can evidence don’t just relate to visiting issues and the Human Rights Act. They also include failings of Social Services departments up and down the country in relation to their duties under Mental Capacity Act.

152. The Mental Capacity Act (2005) was introduced to ensure that the rights, freedoms, and best interests of adults without capacity are central to decisions made on their behalf. However, during the Covid crisis, we saw widespread and systemic failures to uphold these principles. Social Services departments repeatedly failed to adhere to the legal framework outlined by the MCA, which requires thorough assessments of capacity, genuine consideration of less restrictive options, and involvement of families or advocates in decision-making processes.

153. We saw time and time again how once a capacity assessment was undertaken in relation to accommodation, residents were not only presumed to lack capacity in all areas of decision-making but also en masse without any consideration of their individual ability. In addition, Covid policies like blanket visiting bans not only breached the MCA’s legal requirement that decisions are only taken for an individual, never for a group, they also entirely failed to meet the legal requirement of ensuring that all decisions made were the ‘least restrictive’ option.

154. Furthermore, our families experience of Best Interest practices, meetings (which we sometimes attended with them) and paperwork (much of which we read) almost always demonstrated numerous breaches of legal requirements. We also frequently despaired at the involvement of professional Advocates, who repeatedly expressed views that simply mirrored the wishes of the local authority, the commissioners of their service. As you will see from our testimonies, failure to uphold Mental Capacity Act legislation was significantly detrimental to the care home resident, sometimes with devastating consequences.

155. These breaches represent failures of care home providers to work within the required legislation, as well as a failure of the regulator to ensure that expectations around MCA expertise and implementation were meaningfully upheld. However, the most worrying aspect of the breaches was how often we communicated our concerns about serious illegalities with Team Managers and Directors of Social Service departments who simply ignored the issues. Consequently, we can evidence the systemic failure of numerous Social Services departments to understand and lawfully implement this key legislation, exposing a deep-rooted neglect of the rights of those the Act was designed to protect.

Inappropriate Use of the Deprivation of Liberty Safeguards Orders

156. Social Services departments up and down the country also repeatedly failed to meet the legal requirements of the Deprivation of Liberty Safeguards. Instead of DoLS legislation providing a mechanism for protecting the human rights of care home residents who lack capacity, Social Work departments were using them as something akin to a prison order.

157. Numerous families wanted to bring their loved ones home during the Covid crisis but were told that they couldn't because there was a DoLS order in place. Families kept being told that they would have to take their case to the Court of Protection (with their extensive delays) before their loved ones could be returned to the loving care of their families. We repeatedly had to explain to both families and Social Workers that, in fact, the Local Authority simply needed to complete Part 8 paperwork and the DoLS order could be ended on the same day.

158. In addition, we professionally reviewed sets of DoLS application paperwork for our families and found almost all of them failed significantly to meet all Best Interests and DoLS legal requirements. Again and again, paperwork showed a significant lack of understanding about expectations of the law, which must predate the Covid crisis and reflect badly on Social Workers' education, training, management and regulation.

159. However, these failings were brought to light as a result of the Covid crisis because so many families very sensibly wished to bring their loved ones home during the crisis. We helped as many individuals as we could to return to the loving care of the families. However, with others, we couldn't get Social Services departments to uphold the law and allow these residents to be returned to their families. Now we can only evidence the legal failures of these departments and show how their inaction directly led to vulnerable adults dying unnecessarily before their time in appalling care home circumstances that will haunt their families forever.

160. Throughout the crisis, Social Workers, Managers and Directors in numerous areas showed themselves unable to meet the requirements of legislation framing their work. Social Work roles require a decent level of understanding of relevant legislation and we saw that numerous Social Services departments are simply unable to demonstrate that competence these days. This means that there are no working safeguards in place for our most vulnerable citizens.

Help to Challenge Illegalities

161. Many of the families we worked with had tried to involve solicitors in their cases and, typically, they would tell us that they had rung every firm in their area and not one solicitor was willing to take their case on. This was never for reasons of the law but simply because care home cases are not considered commercially/financially advantageous.

162. Many families also tried to seek assistance from the Office of the Public Guardian (OPG) and the Court of Protection but, among other issues, a referral to them would see families waiting months and months for any meaningful action. We were told by the OPG that Safeguarding investigations could take 12 months or more to be conducted and then Court delays would mean that it could take another 12 months before matters came to Court. This type of delay rendered the system almost useless, with most care home residents in need of urgent legal intervention and unlikely to live long enough for their case to even get to the Court.

163. Finally, almost all our families tried reporting visiting illegalities and a raft of other very serious concerns to CQC. In most cases, they were simply told that CQC can't respond to complaints about individual homes; they could only make a note of issues for future investigations.

164. Peoples Care Watchdog can evidence how our most vulnerable citizens were left unprotected by statutory services during the Covid crisis, despite the important pieces of legislation that are in place specifically for their protection. And unless outcomes from this Inquiry create meaningful change, the Covid crisis seems to have proved to all parties that they can expect to get away with unlawful and appalling treatment of our country's most vulnerable citizens.

Our Views On The Management Of The Pandemic In Adult Social Care

165. We have covered many of our concerns relating to the management of the Covid crisis in other answers, so we won't revisit those here. However, there were other significant failures of crisis management, which we believe directly contributed to the unnecessary suffering and preventable deaths of thousands of our vulnerable citizens:

Failures in Infection Control and Prevention

166. The Inquiry is already aware of how poorly infection control was managed within numerous care settings and the varied reasons for this. We expand on care homes misuse of infection control as a means to control families' access to supporting loved ones, while demonstrating negligent infection control practices themselves.

167. TT's daughter , an experienced ex-nursing home owner and registered nurse, whose mother was in a care home, witnessed endless infection control failures. She states: *"Control of infection is highly specialised and requires appropriate knowledge, training and supervision. Care staff simply didn't have the necessary level of expertise and experience, which put both them and their charges at risk. The very poor infection control practices I witnessed during the pandemic not only defeated their aim of reducing the spread of infection, they risked exacerbating it.'*

Examples of poor infection control witnessed during lockdowns include:

168. **Disposable Gloves and Aprons** Families witnessed single use gloves and aprons not being changed as care staff moved between care tasks with different residents and we know from whistle-blowers that many care providers continued to ration the use of gloves during the crisis, just as they had prior to the pandemic.

169. **Face Masks:** Despite face masks being Intended for single use in medical settings and only effective if used correctly covering both mouth and nose. Families witnessed that masks were:

- Put in carers pockets for later use
- Removed from the face and screwed up in palm of hand with no hand washing
- Touched, adjusted and repositioned by the individual wearer
- Worn beneath the chin, pushed up to the hairline or hanging from an ear

170. **Isolation of Infected Residents:** Isolation would only ever be effective if staff were trained in the specialist 'barrier' nursing techniques used in a hospital environment. During the crisis, when Covid infected patients were admitted directly from hospital to care homes, care home staff untrained in this specialism would have been unable to prevent the spread of infection to other residents. As our families all witnessed failures of infection control, many spent months on end worrying that hospital patients would be or were being discharged to their loved one's care home.

171. **Infection Control as ‘Control’** As well as demonstrating professional incompetence in infection control, many care homes used it as way to keep families at a distance. The use of illogical and unlawful, infection control claims by many care homes can only be described as abusive. For example, we repeatedly heard from families that even window visits had been banned, without any reason. This added to distress for both the resident, whose family seemed to have abandoned them; and for families, who were now deprived of the opportunity to even check visually on the welfare of their loved one. As our families’ testimonies evidence, banned window visits also created environments where neglect and abuse could flourish.

172. Similarly, after Government guidance in July 2020 suggested supervised visits should happen in high tier areas, many care homes only allowed supervised visits even after guidance was changed. This was a pointless and unjustifiable policy at any time, as each visitor had tested negative for infection and would clearly be heavily invested in ensuring that their loved didn’t catch Covid. This practice was illegal (a breach of the Human Rights Act and the Mental Capacity Act) and an abuse of power by the care homes. It also very significantly reduced the number of visits any care home could facilitate, as well as taking staff away from caring for other residents.

173. These types of non-evidence based, heartless and illegal ‘infection control’ measures were repeated by numerous care homes across the country. Time and time again, PCW and our families raised concerns with everyone from Social Services departments to CQC and their MPs, almost always without anybody intervening to stop what amounts to clear institutional abuse.

174. **Devastating Infection Control Failings** In some cases, the commercial concerns of corporate care home providers took precedent over infection control measures with devastating consequences. For example, whistle-blowing carers from one care home told us how poorly two staff infected with Covid had been dealt with. Instead of taking the required steps to try and prevent the infection spreading through the home, management simply told the staff members to state that they had colds. Covid then spread quickly through the home, leading to a number of resident deaths. We reported this to both Social Services senior management and the Police. Nobody was ever held accountable for this criminal wilful neglect.

175. These failings happened despite the sector’s myopic focus on ‘infection prevention and control’. At the same time, there was also a very evident failure, by Government and across the sector, to undertake any of the wider risk assessment and risk management work that the crisis so obviously required.

Failures to Undertake Wider Risk Management Work

176. Risk assessment is a fundamental component of effective crisis management and one of its aspects is to anticipate and balance varied potential harms, to ensure that measures taken to address one risk do not inadvertently create others. However, during the Covid crisis, care home providers and all outside professionals failed to undertake the necessary risk assessment and risk management work, instead focusing solely on infection control. It is clear, that this failing, had a far more devastating impact on our vulnerable citizens and their families than any of the infection control issues.

177. Our families' testimonials describe the type of suffering caused by the failure of crisis management decision-making to risk assess Covid policies and practices across the care and health sectors. Most widespread and devastating of all of these was the 'locking down' of care homes; the consequences of which would have been foreseen by any competent risk assessment and risk management work that had been undertaken. Instead, fundamental risk assessment and management failures had harrowing consequences for residents' physical and mental well-being and led to untold numbers of preventable deaths.

178. The ability to undertake effective risk assessment and risk management decision-making is a descriptor of professional maturity, across numerous professions. The management of the Covid crisis across the care home sector has shown that our country currently lacks the level of professional maturity and competence across health and social care necessary to safeguard our most vulnerable citizens.

Failures of Vaccine Risk Management and Related Illegalities

179. **Care Home Residents** We must also mention here decisions made in relation to the Covid vaccine, including the lack of any meaningful risk assessments relating to the use of a barely tested vaccine on our most frail, elderly citizens. Contrary to media presentations, the vaccine roll out in care homes was not without significant, potential risks and in repeated cases, in what must be every care home, completely illegal.

180. For the previously untested vaccine to have been legally rolled out to a frail group that lacked capacity, there should have been Best Interests (MCA 2005) processes undertaken and documented. For those residents who have someone named as an Attorney for Health and Welfare decisions this process is relatively straight forward. For those without a Health and Welfare Attorney, anything as serious as administering a new vaccine, with unknown side effects and

unknown impact on existing conditions, should have been very carefully considered through due process.

181. However, the reality is that Best Interest decision-making happened in only the very smallest percentage of cases and, as far as we are aware, only in those cases where family members were trying to prevent their loved one from being vaccinated because of their concerns about its safety.

182. Our families were often told unlawfully that having the Covid vaccine was mandatory in their loved one's care home. One of our members was even told that he couldn't move his mother back home to her family if she wasn't vaccinated. The unlawful and abusive practices by care homes in relation to the vaccine included the son of one our families actually being held down and forcibly vaccinated. The Human Rights Act was consistently breached, alongside the Mental Capacity Act, and in cases where an individual was held down the vaccination was actually an assault on a vulnerable citizen.

183. We now find ourselves in a situation where two of the four different vaccine types given to British citizens have been withdrawn due to safety concerns. There are also an ever-increasing number of 'serious adverse affects' being recognised and over 100 countries now have some type of Covid vaccine injury compensation scheme. Aside from all ethical issues, professionals responsible for administering the vaccine to individuals without capacity should have been aware of the legal liability to which they were exposed when the administration decision didn't meet legal decision-making requirements.

184. **Families and Staff** Alongside the illegalities of mandatory vaccinations being given to care home residents en masse, numerous families were told that they weren't allowed to visit their loved one unless they themselves were vaccinated. Again, this was a clear breach of legislation and a clear abuse of institutional power by the care homes. It also further demonstrated failures of risk assessment, in relation to residents' need to see family; and was yet another illogical infection control measure, with residents already vaccinated and visitors tested for each visit. Nevertheless, providers were simply allowed to get away with even having this abusive and unlawful policy written into their visiting policies **(EXHIBIT PCW/16 – INQ000588710).**

185. Government's mandating of vaccination for all staff, meant that the sector lost untold thousands of care workers overnight. The Department of Health and Social Care initially estimated that around 40,000 care home staff might leave their positions due to the vaccination requirement, with a possible range between 17,000 and 70,000. Given the staffing pressures that the sector had been facing for many years, this decision was clearly another failure of risk assessment and

management by Government. Despite the policy being reversed four months later, many care workers never returned to the industry and our families have repeatedly reported that the staff that were pressured to leave their posts, were almost always very good carers. They were also people who had diligently cared for our most vulnerable citizens through the worst of the crisis and if tested, vast numbers would likely have demonstrated a natural immunity to Covid due to previous infections.

186. Instead, the care home sector and all involved professionals were swept along in a vaccine frenzy that defied all good sense and competent risk management work, whilst also circumventing all legal requirements. We are now left reflecting on the fact that our most vulnerable citizens, those who are already being horribly failed by a profit-driven care system, have now been subjected to further abuses by a vaccination programme that made $19 Billion for vaccine manufacturers and investors during 2021 and 2022 alone.

Our Concerns Around The Use Of DNA And DNAR Orders And About End Of Life Care During The Pandemic

187. During the Covid crisis, PCW received extensive testimony from families and whistleblowers, evidencing the inappropriate, and at times, unlawful use of end-of-life protocols in care homes and hospitals. These accounts align with reports from other campaign groups and have been corroborated by relatives and care staff at the Scottish Covid Inquiry Health as well as at Social Care Impact Hearings, amongst others.

188. Decisions taken during the Covid period discriminated against all those who were vulnerable due to age, disability or chronic disease. Measures taken in care homes actively contributed to residents' neglect, undermined their health and well-being, and heightened their risk of developing life-threatening conditions. In so many of the cases shared with us, people simply were not afforded the care and attention needed to maintain health or recover from even non-serious medical concerns.

189. Freedom of Information requests evidence that during the Covid crisis, 50% of care home residents who died did so without having been seen by a medical professional. A vast number of families therefore lost their loved ones as a clear result of neglect, inaction and lack of adequate individually tailored medical interventions and treatment. Others lost them to inappropriate and clearly premature end of life medical actions.

190.Analysis of the testimonies and case studies reveal several common themes **(EXHIBIT PCW/17 – INQ000588711).** These include:

The life-threatening impact of remote medical consultations on the frail, elderly or vulnerable. Inappropriate end-of-life prognoses given without clinical justification and/or remotely.

The inappropriate and discriminatory use of 'clinical frailty' scores to justify decisions to not treat and to instead commence end of life pathways and medication.

The inappropriate application of NICE 'rapid response' NG165 guideline to not provide antibiotic treatment.

The discriminatory and unlawful application of DNA (Do Not Admit to Hospital) and DNAR (Do Not Attempt Resuscitation) orders to deny elderly and disabled residents and patients access to lifesaving, life-sustaining treatment (from which they could have objectively benefitted).

Serious concerns about NICE 'rapid response' guidelines NG163 and the inappropriate use of benzodiazepines and opioids (as well as other drugs associated with end-of-life care) which are known to hasten death.

191.We will explore each of these factors in more detail in the following order:

Withdrawal of GP Visits & Services & End-of-Life Decision Making

The Impact of 'Do Not Admit to Hospital' Orders on Excess Deaths and End-of-Life Decision Making

Denial of Antibiotics and Initiation of End-of-Life Pathways (respiratory illnesses and illnesses such as UTIs)

The Inappropriate Use of DNARs to Inform End-of-Life Treatment Decisions

End-of-Life Medications and NICE guidance NG163

The inappropriate use of 'clinical frailty scores' to inform end-of-life decision-making

Withdrawal of GP Visits & End-of-Life Decision Making

192.In early 2020, NHS England's recommendation that GP practices adopt a triage-only system and conduct most consultations remotely led many to drastically reduce in-person access, particularly for care home residents. This shift was implemented without adequate safeguards for the significant medical needs of vulnerable care home residents, potentially engaging Article 2 HRA by risking residents' right to life through neglect and inadequate care.

193.As previously described, (in paragraphs 62 - 74) the impact of the widespread withdrawal of face-to-face medical consultations in care homes had a profound and devastating impact on the health and wellbeing of residents. Medical conditions for which residents would normally have received treatment in the form of antibiotics were left untreated, leaving residents vulnerable to sepsis and other life-threatening conditions. As the excess death statistics for the period attest, many died.

194.Numerous testimonies confirm that many care home residents placed on end-of-life pathways were not terminally ill and could have benefited from proper treatment. Instead, denied adequate consultation and care, they faced NHS protocols that reduced survival chances, even for minor illnesses. The Amnesty International report As If Expendable **(INQ000509643)** notes that between 2 March and 12 June 2020, 28,186 excess deaths were recorded in care homes in England—a 46% increase over previous years. Of these, 18,562 were attributed to Covid-19, leaving 9,624 excess deaths not linked to Covid. These non-Covid excess deaths may plausibly be associated with inadequate access to patient-centred, individually tailored care and medical treatment, though further investigation would be warranted to establish exact causation.

195. While some GP surgeries did resume face-to-face appointments in care homes in the summer of 2020, it was usually on a much-reduced scale. Many GP practices simply chose to continue with remote consultations and, as with so much with pandemic policy, this precedent became entrenched within care home and primary care cultures.

196.With medical staff not visiting and families shut out of care facilities vulnerable residents were reliant on care staff to pick up on illnesses residents were experiencing and triage them for access to remote medical consultation. Care workers have no nursing training, and they often also have little knowledge about residents' medical histories. Families were not able to fill medical history knowledge gaps during this period, having been shut out of visiting, consultation and advocating, leaving residents exposed to misdiagnosis and subjected to inappropriate, sometimes devastating, medical interventions.

197. Families were frequently informed of medical changes for their loved ones only after decisions were made and treatment initiated, their input seldom sought even on the gravest matters. Serious medical interventions, including end-of-life pathways, were often determined remotely, without in-person assessment or broad consultation, sidelining relatives entirely. Some families later discovered—sometimes long after the event—that end-of-life medications had been prescribed to their loved ones without ever seeking their views, a stark breach of trust and process. Often, it took months or even a year for them to access medical records and uncover the truth of what had happened to their loved ones.

198. Considering the conditions under which many end-of-life prognoses were given to care residents during the pandemic, (over the phone and without an examination), it is wholly understandable that many families question the accuracy of these assessments, and it is extremely concerning that decisions to initiate end-of-life treatment were often taken based on information given by care workers only, lacking any clinical knowledge or expertise.

The Impact of 'Do Not Admit to Hospital' Orders on Excess Deaths and End-of-Life Decision Making

199. The controversial use of "Do Not Admit to Hospital" orders (DNA) imposed on care home residents during the COVID crisis was reported in 2020. This can be traced to the guidance from the Department of Health and Social Care (DHSC) issued in March 2020, which included directives to care homes, emphasising the importance of minimising hospital admissions **(PCW/22 – INQ000000000)**. This was followed by a further guidance on admission and care of people in care home initially published on 2 April 2020 but later withdrawn on 1 April 2022. The original version of this guidance is no longer accessible to the public **(PCW/23 – INQ000000000)**.

200. This very discriminatory policy encouraged that resident's with dementia and other cognitive impairments (around 70% of the care home population) be restricted access to emergency and in-hospital care. Care home residents are known to suffer disproportionately from age-related decline and it is therefore astonishing that it was deemed appropriate that a section of the population most susceptible to falls and illness should be denied access to emergency treatment and clinical monitoring. Care homes do not have trained nursing staff on site, and most care staff lack medical knowledge to treat serious illness, wounds, or monitor residents for changes in cognitive function.

201.Concerns about the guidelines and clinical indifference to the needs of the elderly and cognitively impaired were raised by many. For example, Dr. Adrian Boyle, President of the Royal College of Emergency Medicine (RCEM), noting that these policies were discriminatory and prejudiced against older adults, particularly those with dementia stated: *"There is a real risk that policies created obstacles between vulnerable older people and emergency departments, effectively rationing care and increasing the burden on settings that were not equipped to provide 24/7 expert clinical assessment." (The Telegraph, 2020)*

202.The UK Health and Social Care Select Committee highlighted how NHS policies disproportionately disadvantaged older adults and one senior NHS official was quoted in their report stating: "The guidance raised serious questions about its origins, clinical rationale, and the level of scrutiny it underwent prior to publication." The report also confirmed that some hospital trusts adopted policies advising against admitting care home residents, even if they were not terminally ill. The Joint Parliamentary Committee on Human Rights also expressed concern that *"decision-making relating to admission to hospital, in particular critical care, discriminated against older and disabled people*".

203.Although NHS England later withdrew this guidance, families and care staff describe how hospitals, CCGs and GP surgeries continued to discourage or deny hospitalisation for care home residents. As there has been no investigation into the high numbers of excess non-Covid deaths during the first wave of Covid, as noted in the Amnesty report at para. 194, we have no idea how many deaths, Covid related or otherwise, would have been prevented if the individual in question had not been denied hospital care and treatment **(INQ000509643)**.

Denial of Antibiotics and Initiation of End-of-Life Pathways

204.**Respiratory Illnesses and NG165 -** Data from the National Audit Office shows that the number of antibiotic prescriptions initially rose at the very start of the pandemic but then plummeted. This suggests that some care home residents presenting with respiratory symptoms in early 2020, may have been treated with antibiotics for their illness, as was (and remains) standard practice in the management of community-acquired pneumonia and other bacterial infections. However, within weeks of the Covid health emergency, long-standing best practice in the treatment of respiratory illness was largely abandoned.

205.Such was the fear and focus on SARS-CoV-2, that many non-Covid respiratory infections seem to have been entirely overlooked, particularly in care settings. Given the similarities in symptoms between viral and bacterial respiratory infection, the fact that pneumonia can be a complication of both, and that the two can occur simultaneously, it can be difficult for physicians to determine the root cause of infection without a physical, in-person examination and further tests. This is important because establishing the cause of infection is crucial to deciding on the correct treatment, including whether to prescribe antibiotics. By transitioning to remote consultations in care homes, GPs lacked the information needed to determine treatment. These difficulties were compounded by the fact that Covid testing was not rolled out to care homes until September. This meant diagnosis in care homes was based on little more than guess work, despite the obvious risks of wrongful diagnoses and poor treatment decisions.

206. We can presume that there would already have been a tendency on the part of care home staff and absent GPs to worry / assume that those presenting with respiratory symptoms were Covid cases. This would have been compounded by the NICE 'rapid response' guideline NG165 published on 3rd April 2020, which stated that: *"as COVID-19 becomes more prevalent in the community, patients presenting with pneumonia symptoms are more likely to have a COVID-19 viral pneumonia than a community-acquired bacterial pneumonia".*

207. NG165 inexplicably advised medical practitioners to withhold standard antibiotic treatment based solely on suspected Covid, without specifying any methodology to confirm such a diagnosis. At the time of its publication on 3 April 2020, Covid testing was not available in care homes, leaving practitioners to rely on subjective assumptions about residents' illnesses. This absence of diagnostic clarity likely contributed to inappropriate treatment decisions or, worse, the withdrawal of potentially life-saving care. While research has yet to fully quantify the impact of this rapid-response guidance, the well-documented, significant decline in antibiotic prescribing in community settings during this period suggests that many patients with treatable bacterial pneumonia or other non-viral infections were denied proper care. As their conditions predictably worsened, numerous individuals were then shifted onto end-of-life or palliative pathways.

208. There were also widespread delays in antibiotic treatment for urinary tract infections (UTIs) and other conditions which posed severe risks during the period, especially for older people, where untreated infections can rapidly progress to sepsis and other life-threatening illnesses – care home residents are particularly vulnerable here. Too often, the failure to promptly identify and treat UTIs with antibiotics led to significant deterioration and preventable, painful deaths—a recurring issue reported by families. For the elderly and frail, UTIs remain a serious infection and a common cause of hospitalisation amongst care home residents

209. For example, in August 2021, a care home resident was hospitalised with suspected pneumonia and a UTI, exacerbated by severe dehydration initially overlooked by staff. Treated in A&E with oxygen and IV antibiotics, she was later transferred to a ward where, without her daughter's knowledge, she was placed on an end-of-life pathway and deprived of adequate sustenance and hydration. Barred from visiting, despite her mother's advanced Alzheimer's, the daughter was only contacted on day seven to be told her mother was dying, and she was then permitted to see her. She discovered that IV antibiotics and medications for pre-existing conditions, including asthma and anticoagulation, had been withdrawn in favour of palliative care. When she demanded their reinstatement, the hospital refused. Through an urgent Court of Protection case, the daughter secured her mother's discharge and resumed antibiotic treatment at home, addressing the pneumonia and UTI the hospital had ignored in favour of an end-of-life pathway.

The Inappropriate Use of DNARs to Inform End-of-Life Treatment Decisions

210. Another mechanism used to justify ceilings of care and the initiation of end-of-life pathways, were the unlawful use of DNAR's (Do Not Attempt Resuscitation) orders. It is now very well known that across many, if not almost all, care settings, these were placed on residents' medical notes in a blanket fashion, often without discussion with families, or with families put under considerable pressure to agree to the DNAR order. Those who suffered from cognitive conditions or impairments were particularly at risk, regardless of their age and wider health.

211. As one family member stated: *"having dementia on your health records is a DNAR death sentence"*. From the evidence available to us, this would indeed appear to be the case. The combined application of DNARs, clinical frailty scores' and 'treatment ceilings' saw many residents and hospital patients denied access to life-saving treatment. These were not people who were dying; they were vulnerable people in need of treatment and care.

212. Families across the country have reported the unlawful application of DNARs, in care homes, GP practices and hospital settings and there is evidence of the coercion of vulnerable adults in hospital and care settings to agree to the orders. For example, one patient was visited at their bedside three times in one day and urged to agree. Some lacked the capacity to give their informed consent, but signatures were taken regardless. In other cases known to us, relatives discovered forged family signatures, or notes falsely claiming staff had had a conversation with families and that they had agreed to the initiation of end-of-life care.

213. In one case, an elderly (but not dying) medical doctor was told he was "going to die" anyway and should sign a DNAR. His daughter was told that given this the elderly gentleman did so. She still

finds this extremely difficult to believe, knowing that her father was adamant that he would not consent to being referred to palliative care, which was what the hospital were advising. He was vulnerable and frightened according to his daughter, but of sound mind. Soon after the DNAR decision, he was put on an end-of-life pathway and died. In another case, a daughter found a DNAR decision had been entered into her mother's medical records months before she had been approached about the subject, despite the daughter being her mother's Attorney under an LPA for health and welfare.

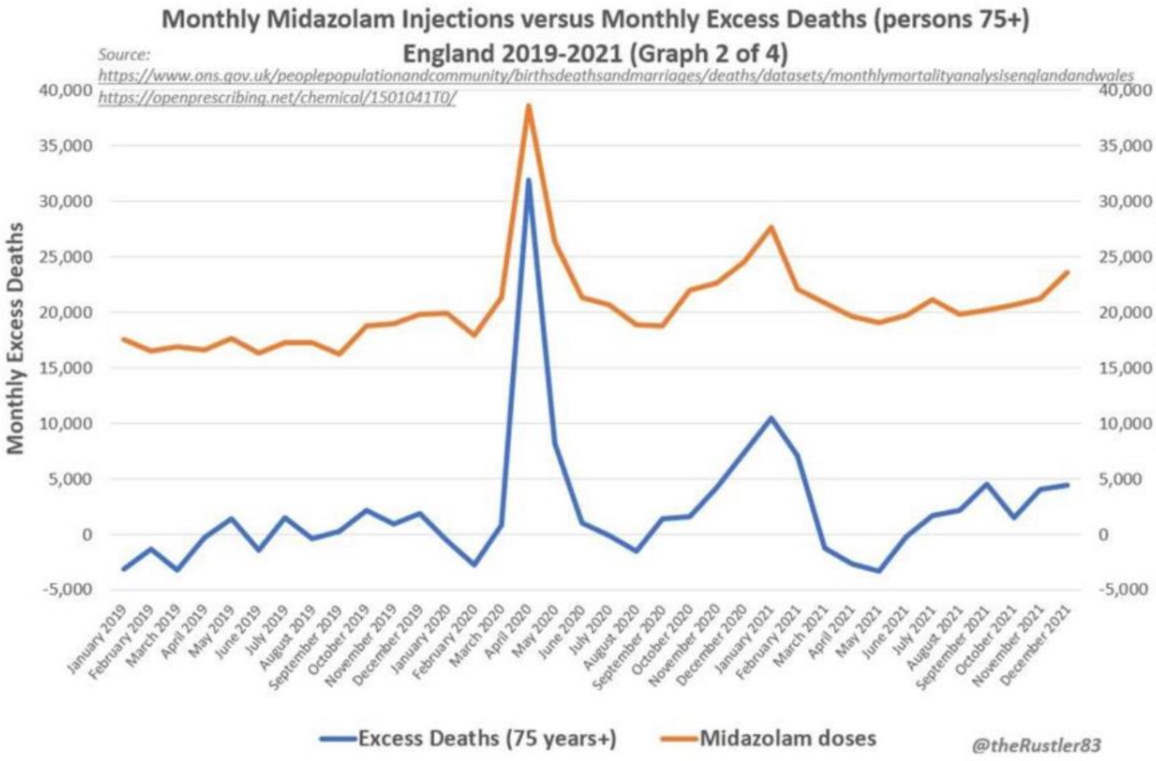
214. Other cases mirror those mentioned above and raise the troubling issue of medical personnel misunderstanding what a DNAR is. The purpose of a DNAR is merely to record a person's wish not to be given CPR in a cardiac arrest situation. However, from the family testimony we have received it seems clear that it is necessary to examine if DNARs were instead used, and indeed remain being used, as justification for withdrawing treatment and placing people on end-of-life pathways. Given the nexus between DNARs, the initiation of end-of-life pathways, and the prescription of end-of-life medications, our families have wide concerns that the scope of DNARs was, and still is, largely misunderstood and unlawfully applied by medical and care professionals.

215. It is alarming that DNAR orders surged to widespread, blanket use during Covid, frequently imposed without families' knowledge or consent, and troublingly intertwined with treatment 'ceilings.' In autumn 2020, Freedom of Information requests to four hospital trusts revealed that 85.4% to 95.5% of patients who died with Covid had DNAR orders—far exceeding pre-Covid norms **(EXHIBITS PCW/17 – INQ000588711)**. This stark spike demands answers: Did all these patients consent to DNARs? How did these orders shape treatment limits and trigger end-of-life protocols? A year later, five trusts stonewalled identical requests, uniformly refusing to disclose data, citing excessive cost as their excuse.

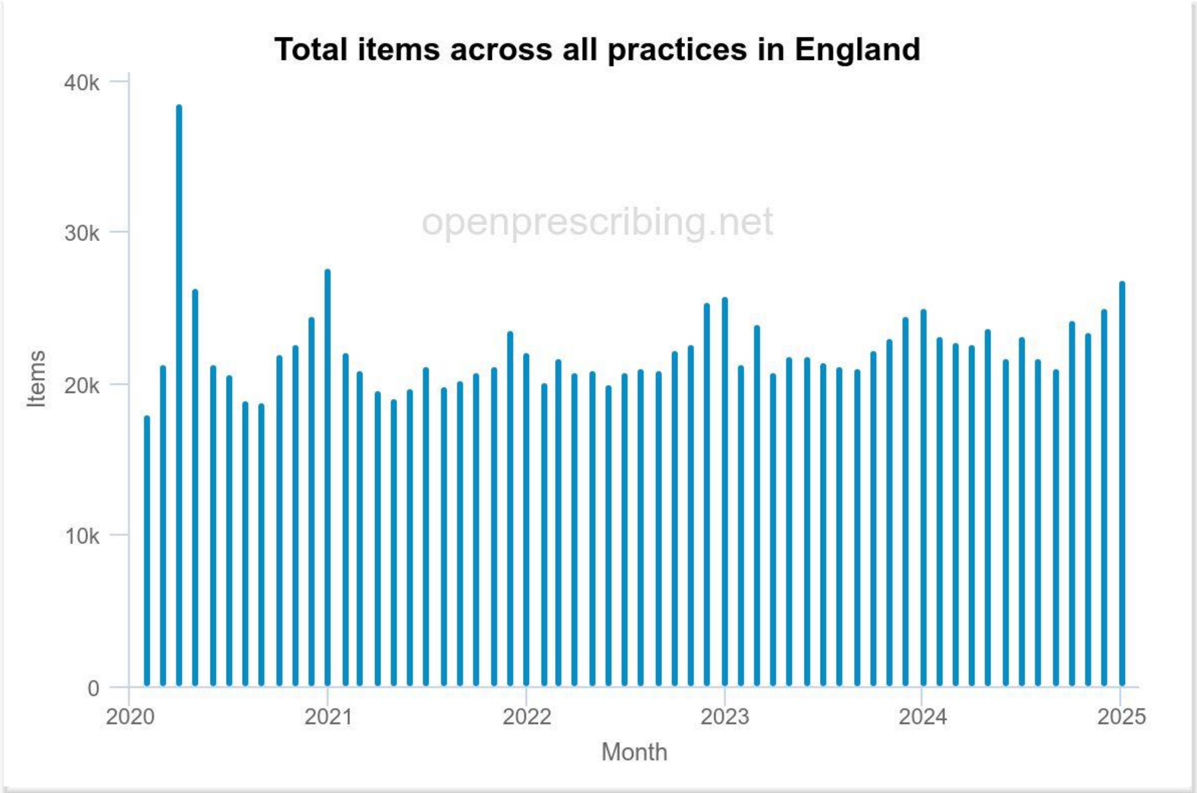
216. It is this type of information, alongside the experiences of large numbers of families across the country that we think necessitates further investigation of the use of DNAR orders during, and since, the Covid crisis.

End-of-Life Medications and NICE Guidance NG163

217. NICE guideline NG163 was issued on 3rd April 2020 and provided recommendations for 'managing symptoms, (including end-of-life care), for COVID-19 patients'. This guidance had a significant impact on the prescribing of end-of-life medications midazolam and morphine.


Monthly Midazolam Injections versus Monthly Excess Deaths (persons 75+) England 2019-2021 (Graph 2 of 4)

Source:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/monthlymortalityanalysisenglandandwales
https://openprescribing.net/chemical/1501041T0/



Open Prescribing Midazolam items 2020-2025

https://openprescribing.net/chemical/1501041T0/

218. NG163 gave the following recommendations:

- Midazolam to manage agitation or distress in patients suspected of having Covid. A dose of 2.5 - 5 mg subcutaneously every 2 - 4 hours as required. This is concerning given that for an average-sized adult, the previously acceptable 24-hour dosage for anxiety and agitation typically ranges from 2.5 mg to 10 mg. A dosage at the lower end specified in NG163 every 4 hours would equate to 15mg over the period, and at the higher end 30mg, very much more than acceptable 24-hour dosing limits, particularly in frail elderly people with low weights.
- Morphine was recommended for managing severe pain and breathlessness in COVID-19 patients. NG163 also emphasised that sedation and opioid use should not be withheld 'due to fear of causing respiratory depression'.
- Minimising face-to-face contact was also recommended, with telephone or video consultations encouraged. This is clearly dangerous given that midazolam and morphine are used as end-of-life medications. Where patients are frail or have complex co-morbidities, a physical examination is crucial for assessing overall condition, severity of symptoms, and the need for specific medications. Midazolam and morphine must be titrated to an individual's needs. These medications have narrow therapeutic windows, and the risks of over-sedation, respiratory depression, or drug interactions are heightened in elderly or seriously ill patients.

219. It is important to note that prior to the Covid era, the combination of midazolam and morphine was not usually authorised for use together for respiratory illnesses. Midazolam is a benzodiazepine used for sedation, while morphine is an opioid used mainly for pain relief. When used together they can cause significant sedation and respiratory depression, which can be dangerous and lead to death. Their combined use is, therefore, considered off-label for respiratory illnesses and instead they are used in palliative care settings to manage symptoms at the end of life; not given as a treatment for someone who it is hoped will recover from illness. The fact that NG163 recommended these drugs together for the treatment of Covid, particularly alongside the midazolam dosage rates suggested, raises very serious concerns.

220. These very serious concerns about NG163 were raised early after its publication, by eminent medical professionals who stated that the uncritical use of the NG163 protocol could "*create unintended risks for people with either suspected or actual COVID-19 infection*". In a letter to the British Medical Journal in May 2020 **(EXHIBITS PCW/18 – INQ000588712)** eleven doctors, including Palliative Consultants, stated that: "*Many people in the UK who are suspected of having COVID-19 will not have advanced cancer or be dying from another existing terminal condition. The accumulating global evidence shows that the case fatality rate reaches >50% in those needing mechanical ventilation, over 80 years and with serious underlying health conditions*

including congestive heart failure, chronic kidney disease and lung cancer. So, it is worrying that while NG163 states "Note that symptoms can change, and patients can deteriorate rapidly in a few hours or less", there is no counterpoint that most patients without the preconditions above will eventually recover".

221. The letter went on to say: *"The combination of opioid, benzodiazepine and/or neuroleptic is used in specialist palliative care settings for symptom control and for 'palliative sedation' to reduce agitation at the end of life. It takes great skill and experience to use palliative sedation proportionately so that extreme physical and existential distress are palliated, but death is not primarily accelerated. NG163 states: "Sedation and opioid use should not be withheld because of a fear of causing respiratory depression." If COVID-19 infection were uniformly fatal, this would be an acceptable statement. But for people not previously known to be at the end of life, there is potential risk of unintended serious harm if these medications are used incorrectly and without the benefit of specialist palliative care advice".*

222. The rationale for NG163 recommending respiratory-depressing medications for a disease targeting the respiratory system defies comprehension. Suppressing breathing in such cases is clinically indefensible, risking severe complications—respiratory failure, hypoxemia, and hypercapnia—that can swiftly spiral into organ failure, cardiac arrest, and death. Even more indefensible is implementing this protocol after only remote GP consultations, devoid of family input on medical history and without consideration of broad-spectrum antibiotics, the latter likely due to NG165's influence

223. Reports from numerous families suggest that NG163 was misinterpreted and misused during the Covid crisis, causing serious harm and death. Medications recommended in NG163 are evidenced in medical records from families within our case studies, who question the appropriateness of the treatment, particularly as it was applied regularly to the vulnerable and those lacking mental capacity to refuse or consent, without consultation as under the Best Interests process.

224. Without a thorough investigation, it remains unclear how many Covid and non-Covid deaths in care homes and hospitals could have been avoided if medications recommended in NG163 had not been administered. However, we do know that the peak number of care home deaths during the first wave of the pandemic occurred within the three months following the release of the NG163 guidance. Additionally, an investigation by OpenDemocracy (2021) into NHS

procurement data suggests that the UK used a two-year supply of Midazolam within just six months in 2020.

225. In addition to the above concerns about NG163, it is also extremely difficult to understand the rationale behind NG163 recommending midazolam be used for 'agitation' in the elderly. This significantly contravenes other BNF/NICE guidance, which recommends other medications such as Lorazepam for agitation in the elderly, and only then when all non-pharmacological interventions have failed. Despite such BNF Guidance, families have described elderly or vulnerable patients routinely being given high doses of morphine and midazolam for agitation.

226. Significantly, and from evidence we have received, not only did the shutting out of relatives contribute to poor clinical decisions leading to use of NG163, it prompted and enabled the Best Interest's procedure to be completely disregarded in such treatment decisions for those lacking mental capacity. We have received family testimony of cases where health and care staff pre-emptively administered sedatives or opioids - even in cases where patients were conscious and not terminal. (Bereaved Families for Justice also reported that relatives in care homes were denied hospital treatment and given sedatives and end-of-life medications prematurely in 2021).

227. The use of morphine and midazolam on the elderly and frail as recommended in NG163, outside of clinical indications, raises significant ethical and legal questions. If a patient was not nearing the end of life, the use of strong sedatives or opioids without proper consent and/or a clear clinical indication would constitute unlawful practice and, in some cases, a criminal act. We have identified the following legal positions that may have been breached as:

228. Human Rights Act Article 2: imposes a positive duty on public authorities to take appropriate measures to safeguard life. This includes ensuring that end-of-life care respects an individual's right to life and that any medical treatment provided is in their best interests

229. HRA Article 8: protects the right to respect for private and family life, which includes the right to make decisions about one's own body and medical treatment. Individuals have the right to make decisions about their end-of-life care, including the use of medication, and where they lack capacity to do so decisions about the same should be made by the decision maker only after following the best interests process, or by an Attorney under an LPA for heath and welfare, following the best interests procedure – see below at (5).

230. HRA Article 14: prohibits discrimination and is also engaged in the context of end-of-life medication. This article ensures that all rights and freedoms set forth in the Act are secured without discrimination. In the context of end-of-life medication, Article 14 ensures that individuals are not discriminated against when accessing medical treatment and support.

231. The Equality Act 2010 is also relevant, as public bodies, including healthcare providers, have a legal duty under the Equality Act to consider the needs of various equality groups when delivering services. This means that end-of-life medication should be provided without discrimination based on age, disability or any other protected characteristic. If end-of-life medication was issued solely based on age, disability or co morbidities during the Covid crisis, this would be viewed as discriminatory as decisions about medication should be made based on an individual's medical needs and personal circumstances, rather than their age or co morbidities alone, to ensure that the dignity and autonomy of an individual is respected.

232. The Best Interests Procedure under the Mental Capacity Act 2005 is engaged in end-of-life medications prescribing. This procedure is used to make decisions on behalf of individuals who lack the capacity to make their own decisions, ensuring that any actions taken are in their best interests. In the context of end-of-life medications, this means that healthcare professionals and caregivers must consider the individual's wishes, feelings, beliefs, and values when making decisions about their care, including what medication is prescribed to someone, and have a duty to consult widely about the same with a person’s family and even friends. Shockingly, in many of our cases we have found that this procedure was widely ignored by care and medical staff.

233. Gross negligence manslaughter – if a medical practitioner unlawfully administers morphine and midazolam knowing it could lead to respiratory depression and hasten death, they could face a charge of gross negligence manslaughter or worse, if the death was foreseeable.

234. Despite the legal positions set out above, numerous families have given testimony to PCW and other organisations describing how they believe NG163 was widely misused during the Covid crisis, with devastating effect. Many families already know that this is a horrifying scandal.

235. Given the specific recommendations made in NG163, it is understandable why comparisons would be made with the protocols adopted at Gosport Memorial Hospital in the 1980s and 1990s, which led to hundreds of premature deaths, and those subsequently adopted under the Liverpool

Care Pathway between the late 1990 and 2014, which was implicated in the premature deaths of thousands of elderly and frail patients. The latter was banned in 2014 following an investigation into its abuse and revelations of ‘barbaric’ practices. Opioids and benzodiazepines were widely used under the recommendations of the LCP (Liverpool Care Pathway), and this has led families and campaign groups to dub NG163 the “LCP rebranded”.

236.While NG163 makes no recommendations to other practices associated with the LCP, such as the withdrawal of active treatment (including antibiotics and prescribed medications for chronic conditions), or the withdrawal of food and fluids, our evidence and that given at the Scottish Covid Inquiry strongly suggests these practices are continuing. Moreover, when NG163 is viewed collaboratively with the protocols in NG165, it is easy to see how a similar pathway to that of the LCP arose.

The Inappropriate Use of Clinical Frailty Scores to Inform End-of-Life Decision-Making

237.NICE guidance NG163 also set out expectations that the **Clinical Frailty Scale (EXHIBITS PCW/19 – INQ000588713)** should be used to help determine whether patients should be admitted to intensive care. Patients with a CFS score of 5 or above (which includes individuals with some degree of frailty but who are still capable of carrying out daily activities with minimal assistance) were initially advised not to be prioritised for intensive care. This raised obvious ethical concerns and following an outcry from disability rights groups and medical professionals, NICE amended its guidance to clarify that decisions should be made on an individual basis, not solely based on frailty scores.

238.Despite this, numerous care home families, as well as staff and health workers, have described how clinical ‘frailty scores, ‘and ‘treatment ceiling’ indicators, were, in fact, used throughout the Covid crisis to justify the withdrawal of care and treatment and the initiation of end-of-life care pathways. This was also corroborated by other campaign groups and by evidence reported by the Health and Social Care Select Committee in 2021.

239.The British Medical Journal (2020) confirmed that some patients with frailty scores as low as 5 or 6 were not being admitted to hospital, with GPs and care home staff instructed to provide palliative care instead. Similarly, The Telegraph (2020) and Open Democracy (2021) reported that patients with mild-to-moderate frailty scores, who would never normally have been placed on palliative care, were being denied hospital admission and instead given midazolam and morphine-based end-of-life medications.

240.When Charles Walker, MP, raised concerns in 2021 about the increased use of midazolam in care homes and the possible premature use of palliative care, ministers from the Department of Health and Social Care (DHSC) defended the government's policies. They insisted that clinical decisions during the pandemic were made on a case-by-case basis and followed the best available medical guidance at the time. This is not borne out in the evidence that we have received from families and surely cannot be the case given remote medical consultations taking place in care homes throughout the Covid era.

241.In response to public concern and Parliamentary questions, despite the NICE guidance, Mr. Argar, the then Health Minister**,** stated that: *"There has been no central directive to use midazolam inappropriately. The increase in use during the pandemic reflected the greater number of patients requiring end-of-life care."* (*UK Parliament Written Questions, July 2021*). When the Department of Health and Social Care (DHSC) were asked about Midazolam prescribing they stated: *"Midazolam is a widely used and well-established medicine for palliative care. Its increased use during the early months of the pandemic reflected the greater number of patients requiring end-of-life treatment at that time."(*DHSC Press Statement, August 2021).

242.In light of all the evidence collected by various organisations, including the case studies of our families, both of the above statements are shown to be very misleading, and the answers given are not borne out in the family testimony we have received. Many families had relatives who were not end of life cases, but were inappropriately placed on such a pathway due to neglect, inattention to their needs, remote GP appointments, withdrawal of support in care homes (SALT teams, tissue viability teams etc), and medical history gaps that were not fulfilled by relatives due to them being shut out of visiting and decisions.

243.Esther McVey MP later joined Mr. Walker's calls for an independent inquiry into the matter, stating that: *"Too many care home residents were denied hospital treatment and instead put on end-of-life medication. We must have a full inquiry into how these decisions were made." (UK Parliament Written Questions, 2021*). Sir Graham Brady (Chair of the 1922 Committee) also argued for an inquiry stating: *"The public need reassurance that decisions made in care homes were ethical, proportionate, and clinically justified. We must investigate whether frailty scores were misused to deny treatment." (The Telegraph, 2021).*

244.In 2022**,** following pressure from these MPs, campaign groups, and bereaved families, the UK government confirmed that care home deaths and end-of-life care decisions would be investigated as part of the official COVID-19 Public Inquiry. Hence, we now find ourselves giving testimony to the Inquiry on events that were not just harrowing for the families involved, but also for all of us working to try and save vulnerable individuals.

245.In offering this testimony, we wish to make it clear that family members were left powerless when it came to end-of-life decisions made by professionals during the Covid era. Many continue to be tormented by guilt and remorse, feeling they were unable to prevent the suffering of their vulnerable loved ones—often without even knowing what had transpired until after their loved one's death.

246.Countless relatives have been diagnosed with PTSD or other mental health conditions. Many express that they cannot "move on" or properly grieve. Families also repeatedly tell us that they believe there has been a deliberate effort to conceal the factors outlined here, and that they will never receive justice or redress for the harrowing experiences they and their loved ones endured unnecessarily.

247.These families are entitled to the findings and accountability that can only be achieved through a full investigation. We are concerned that this cannot be accomplished through a broad public Inquiry, particularly as numerous cases we are aware of clearly warrant criminal investigation. Without a thorough investigation, the suspicious deaths of thousands of vulnerable British citizens during the Covid crisis—often classified as Covid-related deaths—will continue to be obscured, hidden in plain sight.

248.We therefore urge the Inquiry to acknowledge that many of the matters concerning end of life medication and protocols outlined in this statement cannot be adequately investigated and addressed through this public Inquiry. We ask that the Inquiry recommend that Government be advised to investigate these issues fully through more appropriate channels.

249.We also ask the Inquiry to recognise the widespread and consistent violations of laws designed to protect the most vulnerable members of society throughout the Covid era, as highlighted in this submission—especially in relation to DNAR applications, end of life protocols, and the failure to adhere to best interests. This appears to be an institutional issue affecting not only care homes, but also the care home regulator, hospitals, hospices, and the police, many of whom failed to act to protect vulnerable people being subjected to cruel and unlawful procedures. These are serious allegations, substantiated by our case studies which reveal the immense suffering endured by residents and their families throughout the period. Alarmingly, many of these practices appear to be ongoing. These matters cannot be properly investigated or addressed through a public Inquiry, and we therefore also urge that they be recommended for a full investigation through more suitable mechanisms, focusing particularly on how the legal framework is routinely failing our vulnerable population across multiple institutions.

250. In conclusion, based on testimony from families and whistleblowers, we believe that NICE and NHS protocols and practices implemented during the Covid period had a devastating impact on the elderly and frail. In some cases, these practices may have contributed directly to the spike in excess deaths in UK care homes and hospitals during the spring of 2020, as well as the broader rise in excess mortality throughout the pandemic. We also contend that these protocols set troubling precedents in the care and treatment of elderly and vulnerable individuals. It is our hope that the evidence and insights provided in this submission will therefore inform the Inquiry's deliberations and help to identify the mistakes made in care home decision-making and healthcare policy responses, and the broader lessons that can be learned as a nation moving forward.

Did Anything Go Well With The Response To The Pandemic?

251. We have struggled to come up with anything positive to say about the response to the pandemic; because, for our country's most vulnerable citizens in care homes, the suffering was immense.

252. However, the facts are that for private care home providers there is clear evidence that a number of things did go well during the crisis. Firstly, and most significantly, an extra £2.1 billion of public money was given to care homes. This made the crisis so profitable for care providers that, in the first year of the crisis alone, investors saw an increase of 11% on the dividends they were paid in comparison to the year before. Additionally, the UK privatised care sector has become an even bigger target for private equity investors, with 150 new deals done since 2021.

253. While thousands of our country's elders and vulnerable suffered previously unimaginable levels of neglect and abuse in care homes during the crisis, privatised providers and investors were rewarded with significant financial gains **(EXHIBIT PCW/20 – INQ000588714)**.

254. Secondly, the Covid crisis seems to have shown care home providers that they can operate with no fear of meaningful consequences for practices that once would have drawn serious criticism or legal repercussions. It appears that systemic regulatory failures, poor safeguarding practices and a lack of effective quality control in contracting work will usually allow providers to get away with delivering neglectful and even abusive care .

255. Many care home providers have also seen they can treat families and their concerns, with disregard without fear of repercussions. Our cohort has repeatedly described inappropriate and aggressive behaviour by care home providers, simply for raising legitimate concerns about care quality. They also describe how often providers were colluded with by local councils, social workers and regulators.

256. Therefore, it can be concluded that care home providers gained in many ways during the crisis, whilst our country's vulnerable suffered terrible harm.

To Stop Such Appalling Suffering from Continuing / Happening Again in Future Pandemics

Tackling Law Breaking

257. First and foremost, we believe that meaningful change could begin with this Inquiry asking the current Government, led by a man of the law, to put an end to the massive widespread law-breaking that we know is still continuing to this day across the care home sector, local councils and other statutory bodies.

258. The vast number of legal abuses that happened during the Covid crisis led to terrible suffering; and an endless number of actual crimes were committed against our most vulnerable citizens. The experience of Britain's vulnerable through the Covid crisis shows just how little regard is shown for our laws by health and social care professionals, local Councils and locally elected representatives.

259. This Inquiry offers us the opportunity to call on these statutory bodies and professionals, as well as our locally elected representatives, to better serve the public by upholding the laws of our country. If none of the bodies implicated in the crimes and abuses described are held to account and required to change their practices, then vast numbers of our citizens will have been failed by this public inquiry. And the suffering of thousands of British citizens will continue.

260. Therefore, we are asking the Inquiry to ask Government to recognise the legal failings of statutory bodies and care home providers across the country throughout the Covid crisis. We need the Inquiry to help us draw attention to the widespread illegalities that occurred throughout the crisis and the suffering and preventable deaths that resulted.

261. Meaningful change could be created if the Inquiry formally recommended to Government that all statutory bodies, including local councils, receive the clear directive that they must start working within the law. Mechanisms are also needed to enable the public to hold statutory bodies to account for any future illegalities. Then, as a country, we could commit to re-educating ourselves about the legislation that seeks to protect vulnerable people and commit to returning to upholding these laws.

262. We believe that Kier Starmer, with his legal background, could ensure that all statutory bodies return to having a respect for, and working within, the laws of our country.

Safeguarding

263. It is also very important to revisit the very clear failings of Adult Safeguarding across the country. Although, the systemic issues predate the Covid crisis, when the doors of care homes were closed to visitors the incidents of abuse and neglect escalated and this needs to be recognised if it is not to be repeated in future crises. If we want the care sector to become more resilient for future crises, and to safeguard our elders and vulnerable , then we must address what is going so wrong with adult safeguarding services.

264. It is relatively easy to identify impacting weaknesses in the Care Act (2014), resourcing difficulties (across Social Services and the Police) and current workforce capacity/expertise issues. Adult

Social Services departments previously had both the expertise and the commitment to undertake very competent adult safeguarding work. Sadly now, in numerous areas of the country, it seems that neither Social Services nor their Safeguarding Boards can demonstrate either of these aspects.

Risk Management

265. If we truly want to improve conditions in the event of future pandemics, it is imperative that we also increase the health and social care sector's ability to undertake competent risk assessment and risk management work. If the professionals working in and around the care home sector during the Covid crisis had undertaken comprehensive risk management work we would have seen much less suffering and harm, including many less deaths, across the care sector.

266. In the event of another pandemic, further serious failures of both infection control and wider risk management are undoubtedly assured if this significant weakness in the system is not addressed.

267. Senior care home staff need to be able to demonstrate an appropriate level of competence in risk assessment and risk management work, which they were unable to do during the Covid crisis. Therefore, we also need care home providers to ensure that their staff have the risk management expertise that is needed for everyday care home management, as well as future crises.

Rethinking the Increasingly Privatised Care Sector

268. Finally, we believe that all that has now happened across care home sector is evidence that our privatised care home model is grossly failing the British public. Private care providers have shown clearly that do not have the expertise or the motivation to provide the level of care that people should be able to expect when they are infirm, disabled or frail and elderly.

269. Numerous research, reports and studies have shown that the people most benefiting from the privatised care sector are the investors and private businesses making significant profits at the expense of care quality. However, the widespread abuse and neglect that happened behind closed doors during the Covid crisis shows why re-thinking our care system should be an urgent priority.

270. In France a care home scandal also erupted during the Covid crisis when serious care issues were exposed in the private company Orpea, who provide residential and nursing care homes for 32,000 residents. The Orpea care issues, which increased in severity and came to light during the Covid crisis, were systemic profit-driven abuses very like those witnessed across the private UK care home sector.

271. However, in France, within days of the revelations, the Government had responded by launching an immediate six-week investigation, following which a complaint was filed with the Public Prosecutor *"regarding serious dysfunctions observed",* with investigations, raids and arrests in 2024. Government departments also granted themselves "*the right to request the restitution of public funding that was not used for the residents of Orpéa nursing homes*." The Orpea group was then restructured and a public sector financial institution controlled by the French Government became the largest shareholder in the company, giving the Government the control it will need to ensure the safety of its vulnerable citizens.

272. The British Government also has a duty to ensure that the preventable suffering, injury and deaths that occurred in care homes during the crisis never happens again but, without reshaping our care system, there is no way to ensure the safety of our most vulnerable. The corporate warehousing of our elders and vulnerable needs to stop if we want a safe, fit for purpose, resilient, moral and cost effective, care sector.

273. It is often said that the health of a society can be judged by how it treats its most vulnerable members and the public already knows that we live in an increasingly ailing society. However, what happened in care homes through the Covid crisis evidences just how dire things have become.

274. To build a healthier society, one we can be proud of again, we need to acknowledge the failures that occurred in the privatised care sector during the pandemic. From there, we could begin addressing the obvious flaws in the privatisation model and explore alternative systems that prioritise quality care over profits for wealthy investors. There are a number of very good and feasible alternatives and changes to the private care home sector simply waiting to be explored,

such as community run and/or social enterprise care homes. Only by developing new care options will we be able to safeguard our most vulnerable citizens both now and in any future crisis.

STATEMENT OF TRUTH: