Thursday, 29 February 2024

(9.59 am)

MR POOLE: I call Professor Daniel Wincott, please.

PROFESSOR DANIEL WINCOTT (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2B

MR POOLE: Could you start by giving us your full name, please.

A. My name's Daniel Edward Wincott.

Q. Professor Wincott, thank you for attending today and assisting the Inquiry. Can I ask you to, when you're giving your evidence, keep your voice up so that we can hear you but also so that your evidence can be recorded, and if I ask you anything that isn't clear, ask me to rephrase the question.

Professor, you are currently a professor of law and society in the School of Law and Politics at Cardiff University; is that right?

A. I am, yes.

Q. We also see from your report, which we'll come on to in a moment, that you hold undergraduate degrees and masters degrees from the University of Manchester and also a PhD from the London School of Economics; is that right?

A. Yes.

Q. You are also a fellow of the Learned Society of Wales

and a fellow of the Academy of Social Sciences, and I understand you have published extensively on a range of subjects, including on the law and politics of territorial governance in the UK and comparatively as well as on public attitudes to devolution; is that right?

A. It is.

Q. You've published or contributed also to a range of reports, articles, papers and other public domain material that is relevant to the response of the Welsh Government to the Covid-19 pandemic, I think mostly focusing on the implications of the response to Covid for devolution and also the UK's territorial constitution?

A. I have, yeah.

Q. You've prepared at the Inquiry's request a report that we can see at INQ000411927, and that, as we can see there, is entitled "Welsh Government core political and administration decision-making in relation to the Covid-19 pandemic".

At the bottom of that first page is what is described as an author statement, where you refer to your report, to your duty as an expert to provide independent evidence, and to the fact that the opinions expressed in the report represent your true and complete

professional opinion on the matters to which they refer; is that right?

A. It is.

Q. We don't -- we can see there also the date. It's dated 16 February this year.

So, Professor, as the title of your report suggests, you've been engaged by the Inquiry to help explain the Welsh Government's core political and administrative decision-making during the pandemic. Before we look at that in detail, I should say we're going to adduce your report in full in its entirety. And we can see it's fairly lengthy, it contains an awful lot of very helpful information and detail; we're not going to, in the time available this morning, be able to cover all of the topics in your report but what we will try to do is cover the central themes.

Before we do that, I just want to be clear about the mechanics of how your report was put together. Am I right that you were initially instructed last year to prepare a report and that was on the basis of your own understanding of the matters identified in your instructions and materials that you could find in the public domain; is that right?

A. That's correct, yes.

Q. And then more recently, as the Inquiry has obtained its

own evidence, you have been asked to look at some but not all the evidence that the Inquiry has obtained relating to the issues in your instructions; is that right?

A. That is right, yes.

Q. So, for example, the Inquiry has provided you with witness statements that it's received from the Welsh Government's various directorates and key decision-makers, such as the First Minister?

A. That's right, yeah.

Q. Now, you set out at page 84 of your report, we don't need to go to it, but there is a list of the materials that were provided to you by the Inquiry which you've relied on, and then at page 86 you set out the other references upon which you have relied. So are those the principal materials you used to produce your report?

A. They are.

Q. So, Professor, I'd like to start with a few questions about devolution in Wales, so as to provide some context and set the framework for the core decisions that the Welsh Government took during the pandemic. Once we've done that, we'll look at the arrangements and structures that were in place in January 2020, at the start of the pandemic, and then -- before we turn to some of the key events and look at how the Westminster and Cardiff Bay

governments dealt with each other during the pandemic.

So starting with devolution, at paragraph 54 of your report, we don't need to have it displayed on the screen, you describe the model of devolution in Wales as passing through a complicated and politically contested series of reforms, and you specifically reference the Government of Wales Acts 1998 and 2006 and the Wales Acts of 2014 and 2017.

Now, in summary, is it right to say the Government of Wales Act 1998, that established a devolved legislature in Wales, the National Assembly for Wales, which at that time had no primary law-making powers?

A. That is correct, yes.

Q. Then the Government of Wales Act 2006 gave the National Assembly power to pass its own primary legislation under a system by which limited competence was confirmed on a -- I think you describe it as a piecemeal basis, and that's often referred to as the "conferred powers model"; is that right?

A. Yes, that's the first stage of the conferred powers model.

Q. Next chronologically we have the Wales Act 2014, and I think I'm right in saying that that extended the National Assembly's legislative competence in relation to certain tax matters, and then the 2017 Wales Act and

that changed the system from a conferred powers model to a reserved powers model, and that's consistent with the models that are adopted in Scotland and Northern Ireland; have I got that broadly correct?

A. That's broadly right. I would add one further change, which was the change under the Government of Wales Act 2006 from the initial model, which moved powers piecemeal to Wales in a series of fields, and then what were called full legislative powers following a referendum in Wales where the full range of conferred powers were given at the same time. So it's been a complicated and constant process of change.

Q. Well, as you say, I think you describe it -- complicated and politically contested series of reforms?

A. Yes.

Q. Could you just describe in a few sentences for us how a reserved powers model operates.

A. So in principle it means that the devolved parliament or legislature is able to pass legislation on any matter at all except for those matters that are reserved to the Westminster Parliament.

It's correct to say, I think, that that model is -- in Wales, has made Wales more similar to the position in Scotland in particular, but the list of reservations in Wales remains much more extensive than the list of

reservations in relation to Scotland, and that means that the system in Wales is more constrained in the range of things it can do than the system in Scotland.

Q. Thank you, Professor. In a moment I'm going to take you to a table that sets out some of those conferred and reserved powers and we'll have a look at that then.

Just by way of another contextual topic, which is that of the mechanics and the structures that give effect to devolution, if I can I want to group these into three areas: the first, legislation, which, as we've already touched on, is the source of devolved competence; second, the financial arrangements between the various nations; and then, third, the arrangements made for intergovernmental discussion and collaboration. And if I may, I'll just take those in that order.

So, legislative competence first. We've already looked at how that's evolved in Wales, starting with the conferred powers model before changing to a reserved powers model. Is it right to say, at least in principle, that Westminster retains the right to legislate on devolved matters but normally will not do so without the consent of the devolved legislature?

A. Yes, that's right.

Q. And that informal constitutional convention, that's what we've heard -- known as the Sewel Convention?

A. That's right, yeah.

Q. So in respect of Wales, this means that the Senedd must give its formal approval, often in the form of a legislative consent motion, for the Westminster Parliament to legislate in areas under devolved competence?

A. That's correct, yeah.

Q. Mr Gove in his evidence to the Inquiry in Module 2 said that although he is and remains a strong supporter of devolution both across the UK and in England, he also believes that the backstop powers of the UK Government need to be strengthened, and he has said in his evidence that the pandemic revealed the weakness of a devolution settlement that failed to reserve key powers to the UK Government to act in an emergency.

Do you have any comment on those statements?

A. I certainly think the pandemic revealed some weakness and ambiguities in the devolution arrangements. It's not clear to me that those weaknesses relate to the formal ability of the Westminster Parliament to pass legislation in devolved areas. You know, there was, even during the pandemic, legislation passed at Westminster for which consent was sought and -- but that consent wasn't given, and nonetheless the Westminster Parliament passed it, like the UK Internal Market Act.

So the "not normally" provision in the Sewel Convention, you know, is invoked at the discretion of the Westminster Parliament.

Q. Changing tack slightly, in broad terms can you explain the role of the UK Government in policymaking in Wales under the devolution settlement? So does the devolution settlement mean that the UK Government and the Welsh Government really share overall responsibility for policy decisions that impact Wales, each within its own area of responsibility?

A. So I would say, yeah, each has its own area of responsibility, and normally they deal with those areas as two governments which govern Wales.

Q. So as we've touched on already, the boundaries of Welsh competence, and it's section 108A of the Government of Wales Act 2006, that sets out the extent of the Senedd's legislative competence, and I don't propose to go through that in detail but, as I said I would, I'll show you a table.

This is a table that was prepared by Professor Henderson, who gave evidence in Module 2. We see it at INQ000269372, and it's page 12 of the report. This is part of Professor Henderson's report that was entitled "Devolution and the UK's Response to Covid ...", and we see there in the table it identifies

devolved policy areas.

Now, first up, we can see they are not all common, there are areas where one government has a power and the others do not, for example. Now, we obviously are only concerned with Wales in the third column.

We don't need to go all the way down the list, perhaps the most important for our purposes is the first, you see there "Health and social services". So this is a devolved matter in all three devolved administrations. And we can also see in this table other areas such as education, local government, transport, and housing, they're also devolved areas in Wales.

If we can turn over the page to page 13, please, here we see the other side of the coin, namely powers that have been reserved to Westminster in relation to each of the three devolved administrations, and again we can see that the position is not uniform across the three nations. We can see the first three, again looking obviously specifically at Wales: constitution foreign affairs, and defence.

So none of that fits as precisely into our experience of the pandemic as health, as we just saw over the page, but certainly one can see in each of those the question of borders, certainly, which is

something we will come back to look at.

Just returning then back to your report, and we don't need to have the paragraph up, it's paragraph 44, you refer to "jagged edges", that is to say situations where policy objectives or areas of responsibility overlap or span between devolved and non-devolved areas.

Where situations transcend policy areas, so an obvious example being the pandemic, does this mean that the policy outcomes in Wales can to some extent be impacted by decisions of both the Welsh Government but also the UK Government?

A. Absolutely. Yeah, I think we're going to come on to one of the most significant, which relates to public spending, but ...

Q. We'll certainly come to funding and public spending in a moment.

Does that create, in your view, uncertainty about the extent to which Welsh ministers are responsible for the outcomes of decisions in their names?

A. I mean, I think Welsh ministers are still responsible for the -- for outcomes of decisions in their name. I mean, for any government, there's a sort of limited bandwidth, limited range of things that any government can do. So governments have to make choices and some of the choices in the context of the pandemic were

particularly stark. I think that the -- the Welsh Government is particularly constrained by the nature of the devolution settlement and those -- those jagged edges and its relationship with the UK Government. So Welsh Government ministers I think are still responsible for their decisions, but they exercise that responsibility within, I think, particularly tight and, in some respects, uncertain constraints.

Q. Does the existence of what we're calling these jagged edges also mean it's perhaps easier for decision-makers in the Welsh Government to attribute blame for bad policy decisions to the UK Government and also vice versa? I think some have referred to this as creating an accountability deficit. Have you experience of this?

A. I mean, I think there can be confusion over accountability. I think there is a -- often a tendency to kind of use, other parts of the UK and in Wales, what's happening in England as a yardstick, so to note when -- when there's a sense that Wales is doing better than England, and I'm not sure that's always -- with respect to a particular yardstick -- I think somewhere in the report, certainly in some of the materials I saw, there was reference to Wales doing more testing than England at a relatively early stage in -- I think in

some of the core Covid group minutes, and I'm not sure that's a helpful yardstick, and there are certainly blame games played. So, you know, that's a feature of the system. And again I think we may come on to this, the institutions for working together are much less well developed than would be optimal in a system like the UK system.

Although I would say, just very quickly, there are lots of examples of governments working together effectively, going back through the history of devolution on, for example, city deals, where the UK Government and the Welsh Government have kind of collaborated in -- on specific matters.

Q. We'll certainly come on to intergovernmental relations and the JMC structure and things like that in a moment. But just sticking with this question of the consequences of granting devolved powers, is one of, would you say, the automatic consequences of granting devolved powers and decision-making authority to the Senedd policy variation? And if that is the case, what, in your view, are the main benefits and disadvantages of policy variation?

A. I think, you know, devolution is a -- is a machine that creates policy differences or divergences where, you know, governments in different parts of the UK take

different approaches. You know, there's a certain amount of concern about different paths being taken for the sake of difference, but the basic principle, and I think this is reasonably well established and, you know, has been recognised, for example, by the Supreme Court, is that the devolved parliaments and legislatures are authentic democratic bodies and that they authorise governments to pursue their own policy agendas.

So, I mean, I think it's a legitimate part of the devolution system. Potentially it can have benefits of, you know, policy experimentation, so, you know, something can be tried in one place and then adopted in other places. I mean, you know, an example that isn't related to Covid that's often cited here is the use of plastic bags in supermarkets which, you know, is now no longer routinely done in the way it used to be done.

Yeah, I think that's ... you know, so I think it's ... it is a system that generates divergence and, you know, that, in a sense, is its -- part of its rationale.

Q. As you say, it's an automatic consequence, isn't it?

A. Yeah.

Q. If we turn next to the second mechanism and structure that gives effect to devolution, so these are the --

what I mentioned earlier, the financial arrangements between the UK Government and the Welsh Government. In broad terms, matters of national finance are reserved, but that obviously poses the question: how is Wales funded? And at least one of the answers to that is to be found in what is known as the Barnett formula. Now, we mustn't let this become a devolution or an economics seminar but can you please explain in a few sentences what the Barnett formula is and how it works.

A. Right, so, I mean, the Barnett formula is sort of used in, as a phrase, it's used in a number of different ways. Strictly it's to do with the -- how levels of the block grant given by the -- HMT, the Treasury, to the devolved governments, how changes to that are calculated. Broadly speaking, the block grant system is the crucial element and essentially that's under Treasury control and gives block grants to the devolved governments, including the Welsh Government, based on levels of spending for England on matters that are devolved to Wales. So the Treasury decides what's devolved, works out how much has been spent in England, and then gives a population share to -- to Wales.

That process is really, I think, about the Treasury maintaining control of the big macroeconomic features of the UK economy. It tends to happen sort of

retrospectively, so that the level of the block grant depends on what's actually spent in England on devolved matters.

It's also important to note that, and this is quite unusual in international comparison, there are no constraints placed on how the devolved governments can spend the block grant. So if the UK Government spends more on health or on education for England, devolved governments can take that consequential and spend it on whatever their priority is in their -- in their area.

But it does mean that the scope for what you might call demand-led spending in Wales is not present in the same way that it would be present for -- for the UK Government in relation to England. So they couldn't suddenly find another big demand for spending and simply borrow or otherwise find the money to spend on it. They're strictly limited to the grant that they have.

Q. And does that point you've just made there, does that create an extra complexity, then, to the whole question of what powers are devolved?

A. I think it does. You know, so thinking about this in preparation for this session, I think a characteristic of the Welsh Government is a certain sort of conservatism, a reluctance to take on liabilities that may be open-ended. So, for example, in an unrelated

area, the Welsh Government hasn't had the rail system devolved to it. There was a moment when that might have happened and the Welsh Government didn't want it, I think because it was concerned about the liabilities of maintaining an old railway -- an old railway stock. There are a number of other examples of that kind that might relate to aspirational -- "aspirational" legislation that I've described in the report where if legislation grants rights which have financial consequences, then there's a kind of open-ended commitment created there, and I think the Welsh Government has often been reluctant to make those kinds of commitments, simply -- you know, and that's related to the fact that it doesn't have the capacity to necessarily meet open-ended liabilities due to the nature of the financial system.

I'd also say that, in relation to the block grant system or the so-called Barnett formula, you know, I think there's a fairly general consensus that Wales has done, historically, relatively less well compared to levels of need in Wales than, say, Scotland has done from the block grant system, and again I think that's been reflected in a relatively recently innovation of the adding of a so-called "needs-based" element to the block grant calculation for Wales which is unique to

Wales. I think some politicians in Northern Ireland are quite keen on having it implemented there as well.

Q. That needs-based element, that was something that was introduced in 2018/2019. Why did Wales have a higher need than the other nations of the UK?

A. I think it's partly to do with sociodemographics, an older population, it's the nature of the economic base in Wales, you know, there are very few higher rate taxpayers in Wales, for example, levels of poverty are relatively high in Wales and so on. So it's those kinds of needs.

Q. Professor, we might come back to briefly touch on funding again when we talk about the firebreak, perhaps after the break.

I want to now move to intergovernmental arrangements, and the third of the mechanisms and structures that I've referred to a moment ago as giving effect to devolution.

Starting with the UK Government, all of the devolved administrations have their own territorial secretary of state, and Simon Hart was the Secretary of State for Wales during the pandemic.

What would you describe as being the primary role of the Secretary of State for Wales?

A. I think formally speaking the Secretary of State for

Wales is supposed to represent Wales in the UK Government and represent the UK Government in Wales.

Would you like me to expand on that a little bit? I mean, I think there is a sense that this is a role that's perhaps somewhat left over from the pre-devolution arrangements. Again, in the report I quote Robert Hazell, who is a former civil servant and professor at Imperial College London, a report he wrote very early on after devolution where he imagined that, you know, the territorial secretaries of state would be consolidated into a single post or certainly the Scottish and Welsh ones would be, because it wasn't clear to him, and it's not entirely clear to me, you know, quite what that role is.

Q. Certainly during the pandemic, so September 2021, we know that a UK ministerial post of Minister for Intergovernmental Relations was created and that post was occupied by Michael Gove, but prior to that post, Mr Gove had already been playing a liaison role between the UK Government and the Welsh Government in his capacity as Chancellor of the Duchy of Lancaster.

Perhaps you alluded to this already, but how did Mr Gove's role vis-à-vis the devolved administrations fit with the role of a territorial secretary of state?

A. I mean, I think there was some tension within

the UK Government. I've certainly seen documents that have been released to me through the Inquiry that suggest there was some difference of view within the UK Government as between Mr Gove in that role and the territorial secretaries of state who I think felt somewhat sidelined by the liaison role that Michael Gove played with the First Ministers and Deputy First Minister in Northern Ireland.

Q. And from your own research and from the materials that you've seen, to what extent was the Secretary of State for Wales involved in pandemic decision-making in Wales?

A. So I don't think the Secretary of State for Wales was heavily involved. I've seen some material that suggests that he relatively early on saw his role -- saw himself as having a kind of supervisory role that he requested from the First Minister, that the First Minister organise meetings with businesses and maybe trade unions in Wales, and that this seems to have been viewed by the First Minister and the Welsh Government as a sort of a -- an issue that needed to be managed and a diversion of attention from things that they were already doing. I mean, there's quite a lot of material on the role of the Shadow Social Partnership Council, which is a -- had already been set up in Wales, and was kind of ramped up through the pandemic, where Welsh Government ministers

and officials met with businesses and unions, but also civil society organisations and a range of other actors on a regular basis. So that kind of activity was happening, and happening anyway, and I think the First Minister kind of thought that ... it certainly didn't seem to be a functionally productive relationship.

Q. In terms of the architecture that was in place prior to the pandemic for the governments of the four nations to come together, as we mentioned earlier, there was the Joint Ministerial Committee, the JMC, which was established in 2001 by a memorandum of understanding agreed by all four nations. Is it right to say that JMC was intended as a forum for dispute management, where the four nations of the UK could come together and resolve any disputes?

A. Yeah, it was certainly intended to manage the relationship between the -- between the governments. I think its kind of formal dispute resolution role developed, sort of emerged later. But I would also say that I'm not convinced it ever functioned effectively as a dispute resolution forum.

Q. I think you say in your report, you refer to the JMC as offering a "limited and light touch form of [intergovernmental relations]", and then you say you see

it as part of the "devolve and forget" mindset. Can you briefly explain what you mean by this.

A. So, I mean, I think there's a general consensus amongst sort of specialists who study these things that the JMC system was relatively underdeveloped and weak by comparative standards. The JMC for Europe was the formation that met most regularly and worked most effectively, and "devolve and forget" is a sort of aphorism that is part of kind of Whitehall terminology that simply suggests that matters were devolved to Wales and Scotland and Northern Ireland and then not really followed up on in Whitehall and that the standard kind of operating practices for governing England, which, you know, in some ways understandably -- it's by far the largest part of the United Kingdom -- just continued within Whitehall so that it was as if nothing very much had changed in Whitehall by dint of devolution.

Q. Now, the Inquiry has heard evidence that there were no JMC plenary meetings during the pandemic, and Mr Johnson said in his witness statement to Module 2 of the Inquiry that he chose not to meet with the First Ministers of the devolved administrations because, in his view, this would have been optically wrong for fear that this would give a false impression that the UK was a federal state, and Mr Johnson says in his witness statement to

Module 2:

"That is not, in my view, how devolution is meant to work."

What's your view about that statement?

A. I mean, I think that's quite an extraordinary statement, really, not least because Mr Johnson himself contradicts it later on in his statement when he talks about the intergovernmental review and the intergovernmental review precisely set up as its apex forum a meeting of the Prime Minister with the First Ministers of the four devolved governments.

I think there's a -- you know, one can obviously read too much into individual words, but I think there's a political significance in the change in that IGR review from talking about "devolved administrations", which is again the standard language of Whitehall and of government in London, to "devolved governments", which suggests more of a level of equality. You know, you might imagine if you were working for the UK Government and told you had to deal with the devolved administrations that you were dealing with a subordinate level or a level that you needed to supervise rather than, you know, a government that was dealing with core central government policy matters in Wales or Scotland or Northern Ireland.

So there's an internal contradiction there, and I ... so, I mean, I'm, you know -- I wouldn't speculate on what was going through Mr Johnson's mind as he wrote the document, but that "optically wrong" seems to me to be a very strange way to talk about part of the management of a pandemic, really.

Sorry, I'd just note one other thing. You know, I think in his statement Mr Johnson talks about the meetings between Michael Gove as CDL, Chancellor of the Duchy of Lancaster, and later Minister for Intergovernmental Relations, and the First Ministers as being the equivalent of a JMC, but it's quite striking then that in the annex to his report he lists those meetings as ad hoc and informal.

So, you know, if the JMC is the formal set of arrangements that should be used and that I think several senior civil servants recommended should be used, it seems odd and inconsistent then to treat the organisations -- the meetings that he was saying were the equivalent of the JMC as ad hoc and informal meetings. Again, it seems like a fairly low grade way of managing what, at least in Wales, would be seen as kind of an important part of the management of the pandemic.

Q. So would it be right to say that your view would be that

the CDL meetings or calls that happened over the pandemic, they were not a suitable substitute for the JMC plenary meetings?

A. Certainly in formal terms that's correct, although the historical record of the formal meetings of the JMC don't necessarily suggest that would have been an effective forum for dispensing or making decisions. You know, the -- again, I don't want to rush ahead, but the ministerial implementation groups, which had all the authority of UK Government Cabinet committees, you know, had devolved representation on -- you know, and participation, and, you know, whilst I can see, and in his own witness statements Michael Gove has elaborated on the tensions and the lack of a perfect system and so on, I can see that that might be a cause for concern of other UK Government ministers in relation to bringing devolved governments into decision-making, into the heart of UK Government decision-making. You know, that was a mechanism that I think achieved that to a much greater extent either than the plenary JMC might have done unless it was constituted or put into action in a way that was -- marked a difference with respect to previous operation of JMC planning(?) ...

LADY HALLETT: Professor, can I just interrupt for a second --

A. Sorry.

LADY HALLETT: -- and perhaps play devil's advocate. Mr Johnson is obviously a unionist.

A. Yes.

LADY HALLETT: And we don't have four nations that are autonomous, entirely autonomous, and have just come together for mutual defence and all the rest of it. So surely his argument would be that the United Kingdom is -- the United Kingdom Government is technically the government for the whole of the United Kingdom, and therefore you don't treat the First Ministers -- I'm not saying this is my argument, I'm just pushing forward a possible contrary argument -- as you would treat the Prime Minister of country X that had come together with country B and all the rest of it.

Wouldn't that be the unionist argument?

A. I'm -- right. So I'm certainly not arguing that the -- that the -- that weren't kind of difficult choices to be made between different ways of involving devolved governments in the management of the pandemic, that there would be cost to them and so on. The -- aside from the ministerial implementation groups, though, it seems to me that the arrangements did mean that the devolved governments in general and the Welsh Government in particular were kind of informed about rather than

involved in decision-making. I don't think you would necessarily have to have kind of suggested that the four parts of the UK had come together for mutual defence to -- only to -- to make that kind of argument.

Sorry, I'm stumbling a bit here --

LADY HALLETT: Don't worry. We could --

A. I --

LADY HALLETT: -- in this way, perhaps: that whatever your argument that Mr Johnson would promote about unionism and not, as it were, treating the First Ministers in normal circumstances as equals because technically in law they're not, whatever the arguments may be, but in a pandemic, your argument is, whatever you may normally think about how these arrangements work, in a pandemic, because you've all got to work together, then you've got to make sure that you've got proper arrangements; does that summarise it?

A. I certainly think that's right that in a pandemic one might expect, you know, other kinds of rivalries or differences of view to be put aside, and that's an argument that could be made to any of the principals involved here.

I suppose I'm struggling a bit with what is meant by a unionist argument, because someone can be a unionist, as the First Minister in Wales is a unionist, and still

argue strongly for devolution and the involvement of devolved leaders in core decision-making processes in a way that would be -- in fact, it might be quite a strong unionist argument to say that there should be more of an apparatus for managing the relationships between the governments which respects the responsibilities of each government.

You might think of it more as a kind of argument that might be made by people who -- by those political parties that want to leave the UK, that they don't want to be too entangled in arrangements for UK Government as a whole. So unionism can include what you might call a -- I won't try and call it that -- a unitary view of the union and it can include a devolved view of the union, and I think Mr Johnson's view is a very unitary view of the union, which emphasises strongly the ... the role of the central UK Government. In that world, then one would want to see rather more care and attention and interest paid to matters in Wales, in this case, or Scotland and Northern Ireland in other cases, than it seems to me is evident from the documents I've seen.

I've seen, for example, in -- and it's not just political, I think it also influences the civil service. So if you look at the advice given by Sir Mark Sedwill and then by Helen MacNamara and Simon Case, you see

initially discussion of how the devolved administrations, as the documents say, would be involved, and then in -- at the latter end it's about how the DAs would be managed, and it's not clear to me that a workable system of devolution can be -- that has a legislative parliament can be properly governed if the UK Government sees itself as managing the devolved administrations.

LADY HALLETT: Thank you very much.

Long time taken on it, Professor, but now I know why. I shouldn't -- anyway, thank you, that's very helpful, thank you.

MR POOLE: Yes, I think devolved waters run deep, Professor, and we will move away from devolution now and talk about Welsh Government decision-making structures, if we can.

If I could, please, have INQ000066086 on the screen.

This is the organisational chart of the Welsh Government as it entered the pandemic. So at the top we can see the First Minister. Underneath we then have the various Welsh ministers and deputy ministers. Then have, at the time, Shan Morgan, who was the permanent secretary who leads the Welsh civil service. And then beneath the permanent secretary you have the four director generals, so at that stage there were four groups: the Office of the First Minister and Brexit

Group; Health and Social Services Group; Education and Public Services Group; and Economy, Skills and Natural Resources group.

So, first of all, we can see from that there are fewer groups than there are Welsh ministers, so a corollary of that is that the groups are not led, so to speak, politically by a designated department-type Cabinet minister. Do you see that as an advantage or a disadvantage when it comes to effective decision-making?

A. I mean, again I'd say, at the risk of sounding like an academic again, you know, there are -- there will always be advantages and disadvantages. I mean, I suppose a disadvantage might be less capacity for a political minister to drive through a particular policy objective, you know, with the support of a committed group of civil servants. I suppose the advantages would be more in the area of joining up -- you know, linking up across different domains of Welsh Government activity.

Q. Does the structure of the Welsh Government have any implications for the significance of special advisers to Welsh ministers?

A. Yes, I would -- you know, I think ministers in all the governments in the UK rely very heavily on their special

advisers, but I think they do play a particularly important role here, you know, given that you don't have a kind of senior civil servant team around each, each minister.

Q. In terms of decision-making during the pandemic, you make a comment in your report, you say that before you were given access to the Inquiry material your impression was that the decision-making processes in Wales during the pandemic were, in your words, overly complex, but then having worked through the full body of material that you have been given access to, you say "a rather more coherent pattern of response from the Welsh Government has come into focus".

I just want to ask you, your initial impression, then, of over-complexity, was that due to the sheer number of entities and mechanisms within the decision-making structure or your understanding of the decision-making process, or a combination of both?

A. So I think it's a combination of both, you know, there -- the Welsh Government did have a number of structures kind of within the government but also, you know, kind of advisory government structures. I think this reflects a kind of orientation of the Welsh Government towards working in partnership. You know, you'll hear quite a lot about kind of co-production and

partnership working in Wales. But I think it also reflects the relative lack of specialist academic work or what you might call kind of long-form journalism specifically focused on Wales. So, you know, by contrast with Scotland and Northern Ireland, Wales doesn't have a strong Wales-focused media. You know, almost all the newspapers in Wales are essentially the London editions, whereas, you know, even the London-based newspapers in Scotland will have distinctive Scottish editions. And that has all sorts of implications for communication and for messaging and so on in Wales.

But it -- at the early stage, because there's relatively little academic research, I was really heavily reliant on what I could find that the Welsh Government had produced in the public domain and then on journalistic accounts, and, you know, I have to say that, you know, for example some of the materials produced by Andrew Goodall, who's listed as Director General, Health and Social Services Group but is now the permanent secretary, are amongst the most complete and comprehensive accounts of Welsh public administration that exist anywhere, I think, you know.

So reading, you know, I kind of understood the system as it operated, but, you know, it hadn't really

been set out in that kind of detail in any scholarly articles, you know, the community of scholars focusing on these things in Wales is relatively small, much smaller, say, than in Scotland.

Q. I understand.

Professor, by way of orientation, you deal with the initial period January to March 2020 starting at paragraph 104 of your report. I don't need you to pull it up. But in terms of that period, so the first few months of the pandemic, in respect of four nation approach there was -- you say in your report it was very much one of co-operation between the four governments of the UK leading up to and including the first lockdown. Is that a fair summary of your assessment of that period?

A. Yeah, I think that's a -- that's a good summary, although I would also say that, you know, there were incidents of kind of friction even during that period of co-operation.

Q. And I think you've mentioned some of those in your report, and we will obviously have regard to those.

If we just go through the various factors within that, we know that during that period January through to March there were a series of COBR meetings, initially chaired by Matt Hancock as Secretary of State for Health

and subsequently by Mr Johnson. Now, there is a debate about whether the right person from the Welsh Government attended. We know Mr Gething attended the first three COBR meetings, Mr Drakeford's first attendance wasn't until the COBR meeting on 18 February. Now, I don't want to spend time on that now, but, as a general point, the Welsh Government was invited to and did attend COBR meetings, whether in person initially or remotely; that's right, isn't it?

A. Yes.

Q. One of the products of those early COBR meetings was the *Coronavirus: action plan*, at INQ000066061, which we can see on the screen there. That's the first page of the action plan published 3 March.

Now, the first point to note, just from that first page, not only does the title explain that it's a guide as to "what you can expect across the UK", but then immediately underneath that box are the illustrative logos showing that it was the work not just of the Westminster Department of Health and Social Care but the three devolved governments, including, of course, the Welsh Government.

If we can please go to page 10 of that action plan, that sets out the well known, as we see at paragraph 3.9, contain, delay and mitigate.

Then the paragraph above, 3.8, it reads:

"The different phases, types and scale of actions depends upon how the course of the outbreak unfolds over time. We monitor local, national and international data continuously to model what might happen next, over the immediate and longer terms."

Would you agree that this anticipates, this action plan, in early March, that there might be variations in response to the virus?

A. I would, absolutely. I would just note one potential ambiguity in this paragraph. It says "We monitor local, national and international data", and it's not clear what "local" and "national" mean in this context. So does "national" refer to the whole of the UK? Does it mean they're monitoring each of the nations, as it were, of the UK? Does "local" include localities in England and then the devolved parts of the UK? So, you know, I mean, this is a standard way of talking about these data, but the complexity of the UK doesn't kind of necessarily sit neatly in that kind of language.

Q. No, Professor, and the questions you ask are good and valid questions and we'll be hearing evidence later in these hearings from people that had a hand in drafting and input into this document.

So we spoke earlier about policy variation being,

I think in your words, an automatic consequence of devolution, so this appears to be expressly recognised in this action plan.

Then if we can have a look, please, at page 17, paragraph 4.40, we see there a reference back to COBR, and four lines up from the bottom:

"The respective crisis management mechanisms across the Devolved Administrations have also been stood up and will operate in very similar terms to that of COBR within their own nations, and all four co-ordination centres are linked up on UK-wide planning and delivery of the response to Covid-19."

So it's fair to say, looking at that, would I be right, that the plan at that stage, this is early March 2020, was very COBR-centred, COBR would be the place where the governments of the four nations would come together and would pursue a combined response to Covid?

A. Yes.

Q. I'd like to just change topic slightly and ask you some questions about the UK Government's legislative response to the pandemic and how -- particularly how that impacted on the Welsh Government's strategic response.

So we know that at the start of the pandemic the UK Government had on the statute books the Civil

Contingencies Act 2004 and that provided ministers with the ability to take emergency powers in the event of a catastrophic emergency and appoint governors, for example, for parts of the UK.

Now, it also had on the statute books the Public Health (Control of Disease) Act 1984, which provides that regulations may be introduced to manage an infection which presents or could present a significant harm to health.

Now, as we have already touched upon, under the Civil Contingencies Act, decisions would be made, and you deal with this in your report, by the UK Government, and the Welsh Government would be a Category 1 responder, so effectively implementing those decisions.

In contrast, Public Health (Control of Disease) Act, public health obviously being a devolved matter, Welsh Government would be the entity making the actual decisions for themselves; correct?

A. Yes.

Q. So did the choice of which legislation to use to respond to the pandemic, in your view, did that have important implications for Wales and also the type of structural response to the pandemic across the UK?

A. It did, yeah.

Q. I think you refer in your report at paragraph 105 to the

First Minister's evidence to the Inquiry that he expected the UK Government to take the key decisions for the whole of the UK and that you refer to the fact that Mr Drakeford's expectation was that civil contingency powers would be the primary instrument used to respond to the pandemic and that this expectation was one that you say was generally held across the devolved administrations.

Now, we know that the decision was made by the UK Government to respond to the pandemic through the use of public health powers, and also the powers under the Coronavirus Act -- and you'll be glad to know I don't intend to get into the fine detail of the Coronavirus Act with you, which of course addressed all sorts of issues relating to emergency measures that were taken and lockdown and so on and so forth.

Would you, though, agree in general terms that one of the purposes of the Coronavirus Act was to facilitate a co-ordinated and consensual approach across the UK but also whilst at the same time facilitating deviation where necessary?

A. Yeah, I think that's right.

Q. So that Act, the Coronavirus Act, that's really of a piece with the approach that we have been discussing relating to, just a moment ago, the action plan, it

anticipated a four nations approach; yes?

A. Yes.

Q. Now, the reason that this is of some interest is that latterly there has been some debate as to whether that particular sort of legislative approach was the right one to have chosen, and as we've just seen, and as you refer to in your report, it's not one that the First Minister anticipated.

Now, Mr Johnson in his witness statement to Module 2 of the Inquiry -- and perhaps we can have this up on the screen, it's INQ000255836, and this is -- yes, page 30 -- this is Mr Johnson's report at paragraph 126, he says:

"Looking back, we should have thought much harder about the legal basis for the measures proposed. There is a respectable argument that we should have used civil contingencies legislation rather than public health legislation. By allowing for at least the appearance of a divergence in approach between the various parts of the UK, we were risking considerable public confusion and frustration -- when clarity of message was crucial."

Then perhaps just one further paragraph of his witness statement.

Paragraph 153, which is page 37, please.

So at 153, I think we are about four lines down, it

starts:

"It would perhaps have been better, in retrospect, if we had formed policy under the Civil Contingencies Act 2004 so as to bind the United Kingdom together. We should then have met regularly, UK Government and DAs, to decide the policy together and to stick to it."

Now, we know from evidence heard in Module 2 that COBR was advised that it wasn't open to the UK Government to use the Civil Contingencies Act to the pandemic because it wasn't an unforeseen event and so the Public Health Act powers were used.

The important point to draw from what Mr Johnson is describing, so namely an alternative legislative response, would have seen, would it not, a very different response to the pandemic?

A. It would have seen a different response to the pandemic, yeah.

Q. We know from what the First Minister has said, and you have picked up in your report, that once the decision was made to rely upon public health powers as the basis for responding to the pandemic, the First Minister agreed with that decision, his words were it allowed the Welsh Government to calibrate a response which reflected the particular circumstances in Wales, but that decision, that UK Government decision to use public

health powers, was not formally made until 20 March. So is it fair to say that what you've seen that up until then, up until 20 March, it appears that the Welsh Government and the First Minister had assumed the primary decision-making power would remain with the UK Government?

A. That certainly seems to be the First Minister's understanding of the situation. I have to say that, you know, trying to track through references to different kinds of powers during that early phase is complicated and I remain a little bit unclear about exactly when, kind of, decisions were -- or exactly how these matters were discussed, how far they were aired and so on, at any earlier stages. So there are references to public health powers, I think, in some earlier documents. But, you know, so there's a certain -- a certain amount -- a certain lack of clarity for me, which I haven't been able to resolve, I'm afraid.

Q. In light of everything we've looked at and discussed, do you feel able to comment on whether the First Minister's assumption that this would be effectively Civil Contingencies Act powers rather than public health powers was a reasonable assumption to hold? Is that something you feel able to comment on?

A. Yeah, I mean, I think I would say it was, kind of broadly speaking, reasonable based on what I understand of the situation. You know, I've also seen in some of Michael Gove's evidence, his in-person evidence, as it were, to Module 2, he has made reference to Michelle O'Neill, the Deputy First Minister of Northern Ireland at the time, also expecting civil contingencies would be the basis of the power. So, you know, I think it's reasonable that that was a fairly widespread view, including across a range of different kind of political perspectives.

Q. Let me move on, but in so doing return to a topic we've already touched on, which is the question of funding.

Now, in your report, it's paragraph 113, you refer to the UK Government's Coronavirus Job Retention Scheme, so that's the furlough scheme. You describe it as providing the foundation for pandemic governance across the UK, including Wales.

Now, we don't need to go through the detail, but in summary the consequence then of the Barnett mechanism that you described eloquently to us earlier was that where the UK Treasury set up these extremely money-intensive schemes, so furlough, bounceback loans, business interruption schemes and so on, the Barnett mechanism meant that there was extra funding for Wales

and the other devolved administrations; is that right?

A. I'm not sure that's quite right. I mean, things like the furlough scheme and the Coronavirus Job Retention Scheme were UK-wide funding streams so that people across the UK could draw on them and they were drawing on Treasury funds. The block grant consequentials came from spending in England on matters that weren't also covered in Wales, you know. And a colleague of mine in the Wales Governance Centre at Cardiff University who works in the fiscal analysis unit wrote a report in -- published in November 2020 where he said at that stage it looked as if in Wales there wasn't disproportionate spending from those central funds as compared to spending in England. So the idea that, as it were, more was spent in Wales from those central funds I don't think -- at least for that first phase of the pandemic, I don't think stacks up.

Q. I understand. And I think you explained earlier that Barnett funding, it's not ringfenced, so in other words Wales doesn't need to spend it in the same way that England has spent it. But you refer in your report, and I don't think we did touch on this earlier when we were dealing with funding, to the introduction by the Treasury of a Barnett or sometimes, I think, called a coronavirus guarantee.

Just in a few sentences could you explain first what that is and why you think that is particularly important in terms of the pandemic response in Wales?

A. Okay, so that relates back to what I was saying previously about -- about how the block grant is based on spending outcomes in England, so that if spending is allocated for England and not actually spent, then any block grant consequential can be clawed back by the Treasury. So effectively what the coronavirus or Barnett guarantee did was it gave the devolved governments comfort that where the UK Government was allocating substantial funds for coronavirus purposes in England, that those funds would be allocated to Wales and the other devolved governments and not clawed back at the end of the -- at the end of the period.

So an example would be the UK Government allocated a huge amount of money for its test and trace system. The test and trace system implemented in Wales was much, much cheaper, but the Welsh -- you know, even if all the billions of pounds -- I can't remember exactly what the amount was, I shouldn't say billions of pounds, but even if the substantial allocation wasn't spent in full, that money wouldn't be clawed back from Wales, so they could then confidently allocate it to whatever purposes they felt necessary, without the risk of it being clawed

back.

This goes back to my point about the kind of anxiety about open-ended liabilities that I think is a kind of significant feature of the devolved arrangements as they work in Wales.

Q. We spoke a moment ago about the involvement of COBR in those early months of January to March 2020. I just want to take perhaps a step to one side again and talk about SAGE, so the Scientific Advisory Group for Emergencies, because you make a few points about SAGE in your report that I just want to look at with you.

A. I'm sorry, could I just make one other point, which I think is really quite an important point, about the structure of public spending and how that affects pandemic response? I mean, not for this pandemic, but thinking about the future.

Q. Of course.

A. If we imagined that coronavirus had arrived first in a population centre in one of the devolved parts of the UK, there's no straightforward mechanism whereby the additional spending required to deal with that as it first hit would be generated in the UK system. So, you know, we know that coronavirus hit in London first and the response was keyed around dealing with that issue. But if, say, a group of academics from China had

visited one of the universities in one of the devolved cities and that had been how Coronavirus had first hit, it's not at all clear how the emergency spending would have been generated.

You know, I suppose it would have had to have been going to the Treasury and asking for some special funding, whereas because it hit in England initially, you know, it was fielded by the standard UK Government arrangements.

I hope that's not ...

Q. That's very --

A. I hope that's been helpful.

Q. So just returning to where I was on SAGE and really a few points that you make about SAGE in your report, I think there are three in total, first you make a point about membership, and you refer in your report, paragraph 119, to the fact that:

"Relatively few people who work at universities in Wales sit on SAGE or its sub-committees (in contrast, proportionately larger numbers of academics from Scottish universities are members of SAGE)."

Briefly, just expand on that point and why you make that point in your report, please.

A. So I think in her report, Professor Henderson kind of talks about SAGE having a kind of English frame of

reference, and, you know, I think that was -- that was sort of partly mitigated by the presence of people who were kind of living the experience of coronavirus in Scotland but to a much lesser extent in England. And obviously that doesn't affect, you know -- academic scientists are on SAGE for their substantive expertise and it doesn't matter, in that sense, where in the UK they live, but if they're bringing their experience to bear, at least on the margins, you know, I think that might be significant.

And I think there's a broader issue about the way that data on England tends to dominate UK-wide data and, you know, there are often issues about, you know, on surveys the sample size in Wales being too small to say anything meaningfully -- meaningful about Wales itself and so on. So I suspect these are the kinds of thoughts that were behind Professor Henderson's remark about the kind of England frame of reference.

Q. I think another point you make about SAGE is that, from what you've seen, Welsh officials and experts did not have direct access to minutes and papers directly from SAGE and its subgroups, although I think it's fair to say that access to SAGE materials did improve, and I think from 8 April 2020 the Welsh Government was given access to an online repository of SAGE documents.

Now, the Inquiry is going to hear quite a lot about the Technical Advisory Cell and Technical Advisory Group, TAC and TAG, that were set up in late February and comprised scientific and technical experts that provided independent scientific advice and guidance to the Welsh Government.

One of the driving forces behind establishing TAC and TAG was that the advice and guidance from SAGE was not Welsh-specific, as we've just discussed.

Rather than creating a completely new advisory structure in the midst of a pandemic, could an alternative approach have been to seek to address some of those problems that you've identified with the SAGE structure with the UK Government, or do you think it was an appropriate or necessary response to set up a new advisory structure in late February?

A. I mean, I think it was appropriate to set up a -- the TAC/TAG structure. The alternative of negotiating with the UK Government to change SAGE isn't one I've considered in any detail, so ...

I mean, I suppose -- I suppose I think it kind of goes with the grain of the sort of public health approach to managing the pandemic, although it -- I'm trying to work out the timeline here. It may be sort of in advance of -- may have been set up in advance of the

First Minister understanding that the -- that the public health legislation would be used. I don't have the dates in front of me, so I can't work out that timeline.

Q. Well, I think TAG and TAC were set up, there or thereabouts, end of February, and I think the evidence might suggest that it's 20 March that the --

A. Right, okay.

Q. -- that it becomes apparent that the UK Government is going to use the public health powers rather than the Civil Contingencies Act.

Now, we're going to explore data and modelling with other witnesses, but because you make one comment in your report, I just want to ask you briefly about that before we take a break.

You say:

"The availability of data and capacity to analyse it in a sufficiently timely fashion to inform policy making, was a continuing issue across the UK and in Wales; perhaps reflecting the structure of the sector these issues seem to have been particularly acute in relation to social care."

Just, as I say, briefly, in your view are you able to say why that was the case?

A. So structurally the organisation of social care across the UK, you know, means it's very much a kind of

mixed -- mixed provision. You know, a lot of independent provision, increasingly less local government directly provided social care, and, you know, that means that you're gathering data from a range of different charitable or commercial enterprises. And so having comprehensive data on the sector I think is -- has proven difficult across the UK and was, I think, difficult in Wales. I think that's been acknowledged and there are kind of data strategies for social care in Wales and so on that were developed subsequent to the pandemic, as I understand it.

MR POOLE: My Lady, I'm going to change topic, so therefore that might be a good place for a break.

LADY HALLETT: Yes, of course.

Professor, I hope you were warned that we take a break for -- we always say it's for the benefit of the stenographer but I suspect it's for the benefit of everybody. I shall be back at 11.30.

(11.13 am)

(A short break)

(11.30 am)

LADY HALLETT: Mr Poole.

MR POOLE: Professor, I'm going to next ask you some questions about the Welsh firebreak, which, as we know, started on Friday 23 October 2020, ended on 9 November.

Now, you deal with the Welsh fire firebreak in the section of your report starting at paragraph 225. Now, we know there are supporters and there are critics of the firebreak, and the evidence as to how effective it was is unclear, and I don't want to discuss any of that with you, Professor. I want to, though, explore two aspects of the firebreak. First, continuation of the theme, differences in government responses. And second, again returning to the impact of funding.

Now, the Welsh firebreak is perhaps, would you agree, the clearest example of the Welsh Government adopting a starkly different policy to the UK Government and the other devolved administrations?

A. It is, it is starkly different. I mean, I think there was something a bit like it in Northern Ireland, but very different to the other governments in Britain.

Q. Perhaps we can just have a look at minutes of a COBR meeting of 12 October.

INQ000083851. And if we could perhaps, please, go to page 7, paragraph 11 of those minutes.

You see here the First Minister asked if COBR would be held to discuss circuit-breakers, which he noted the SAGE papers had regularly advised on.

Then the same page, further down, at paragraph 16:

"The [Prime Minister] said that the issue of circuit

breakers and the ability to keep schools open were particular points of interest."

Continued success was said to be heavily dependent on individuals' behaviour, the challenge lay in successfully encouraging a tired and frustrated population to absorb new messages."

Those minutes can be taken down, thank you.

From what you have seen, would it be fair to say that the UK Government had very little appetite for a circuit-breaker?

A. Yes, I think that's right. You know, there was some very clear evidence in Boris Johnson's Module 2 statement that is very sceptical about circuit-breakers, and specifically, you know, critical of the approach in Wales, and actually contrasts it with a tiered approach in Scotland.

Q. Indeed. And I think you refer in your report to the UK Government's Eat Out to Help Out scheme being an example of, you say, the UK Government giving priority to mitigating economic harms rather than Covid impacts; is that right?

A. There certainly seems to have been an emphasis on that, especially from the Treasury.

Q. Turning then to the impact of funding on the firebreak, and you deal with this at paragraph 227 of your report,

and you refer there to the fact that the Treasury did not agree to extend the furlough scheme to cover the Welsh firebreak.

Now, the Inquiry is going to look at that issue with some later witnesses and I don't want to with you debate the rights and wrongs of that particular episode, but just as a general point, would you agree that this illustrates a point that we touched on earlier, namely the difficulties faced by the Welsh Government not having the fiscal levers to support individuals and businesses that could not earn income during the pandemic?

A. Yes, at a broad -- at a broad level. I mean, I think also there was quite a lot of commentary, you know, ranging from The Financial Times and the Institute for Government through to people like Kelvin MacKenzie that sort of suggested that the Welsh Government might be pursuing tighter restrictions and, you know, passing the bill on to the Treasury, which I think is a serious misreading, misunderstanding of the way the finance actually worked.

Q. Thank you, Professor.

Throughout your report you refer to various lessons learned exercises that were carried out by the Welsh Government and also other organisations such as

Public Health Wales. Now, the evidence suggests that the period from late summer to early autumn 2020 until the winter months of 2021 seem to have been particularly challenging for the Welsh Government.

One conclusion of a lessons learned exercise carried out by Public Health Wales was that not all lessons identified at the end of the first wave of Covid were actioned successfully, and that's something you note at paragraph 224 of your report.

Would you agree that there was an opportunity for the Welsh Government to be better prepared for the second wave of the pandemic in autumn 2020, having been through, obviously, the first wave in the spring of 2020?

A. Yeah, I've thought quite long and hard about this, and for me I think one of the tricky things to work through is -- is how lessons learned in the first wave might be applied in the somewhat different conditions that held from, you know, the summer 2020 onwards.

I mean, it seems to me that there's a quite fundamental difference between that initial emergency response where, in effect, a very large-scale redirection of the NHS was undertaken in Wales and across the UK and then, from summer 2020, much more of an attempt to keep a more normal range of NHS services

going, you know, even through the various kind of lockdowns and so on. So I think there's a danger of a kind of false equivalence, when you say there was a lockdown 1 and a lockdown 2 and a lockdown 3; they're actually quite different kinds of lockdowns.

Now, that still leaves open the question of learning lessons, and it does make me -- make me reflect that I would want our governments to be able to kind of absorb and understand that difference and kind of modulate their response in the face of that difference.

There is, I think, quite a lot of evidence that, due to things like the condition of hospital infrastructure in Wales, that infection protection and control proved particularly difficult, and there are some reports that say, you know, that is due to the physical layout of hospitals in Wales. Now, I haven't seen any kind of comparative analysis of physical layout of hospitals and how that impacted infection rates within Wales or beyond, but it seems to me there is an important point there that governments do need to learn lessons, but they also need to understand that they're addressing a different policy question, you know, perhaps subtly but I think significantly different policy question, if they're trying, as I think they should be trying, to provide a wider range of services, as the pandemic

emergency continued.

Q. Thank you, Professor.

Now, a change of topic, and my last topic is going to be public health communications, briefly.

You deal with this at paragraph 256 or certainly you start dealing with this at paragraph 256 of your report, and you make the point there, which is a point you made earlier this morning, you say:

"Compared to Scotland and Northern Ireland, the Wales-specific media is weak, especially in relation to newspapers."

So printed media is weak, as you explained earlier.

Is it right though to say that Wales does have a distinct radio and television provision, particularly in the Welsh language; that's right, isn't it?

A. Yep, in the Welsh language. And, you know, there is also a distinct provision in English as well.

Q. You refer in your report to daily broadcasts of the Welsh Government press conferences, which I think started on 30 March 2020, and you describe in your report as BBC Wales reporting an unprecedented demand for its news output, with more than 700,000 viewers tuning in each day. Would you agree that those daily broadcasts were a key part of the Welsh Government's public health communications strategy?

A. Yes.
Q. In your report you also note that although Mr Drakeford's popularity dipped briefly in Wales at the start of the pandemic and Mr Johnson's increased, Mr Drakeford's ratings then increased sharply as Mr Johnson's fell. And I think I'm right in saying you're a member of the Welsh Election Study.

And if we can have, please -- it's at page 79 of your report, INQ000411927.

Look there at figure 1. This is data I think collected by the Welsh Election Study to compare public attitudes in Wales towards the UK and Welsh governments' handling of the pandemic.

We can see there from figure 1 a clear common pattern of higher approval levels for the Welsh Government than the UK Government in terms of communicating decisions handling lockdown and vaccine roll-out.

Overall would you say that the Welsh Government employed an effective public health communications strategy during the pandemic?
A. I would say overall it did. I think there were, you know, specific examples of mishandled issues. You know, for example there were issues around the firebreak to do with non-essential items in supermarkets

and how they were handled and so on, but in general I think the evidence is that their communications strategy was relatively successful.
MR POOLE: Professor, thank you very much. I have no further questions for you.
LADY HALLETT: Ms Shepherd.

Questions from MS SHEPHERD

MS SHEPHERD: Professor Wincott, I ask questions on behalf of Covid-19 Bereaved Families for Justice Cymru, and the question that I've got to ask you relates to the evidence of Professor Thomas Hale, which he gave in Module 2 of this Inquiry.

The reference is PHT000000030, and it's page 26 of that document.

If we could look at the top left-hand quadrant, and it's line 21 onwards, he says:

"So we see this rollercoaster tendency where restrictions are put into place only after it becomes apparent there will be a very severe threat to the health system. That's after a large amount of community spread has begun. Because it's so prevalent ..."

And it goes over to the next page:

"... at that moment, the restrictions need to be more stringent and to be in place for a longer period of time than might have been the case otherwise, but

precisely because sustaining high stringency for a long period comes with costs, there's huge pressure to roll them back sooner rather than later and that leaves, inevitably, some residual virus circulating in the population, which lays the seeds for the next wave to emerge. So this kind of tendency to act too late in the first instance and to take measures away too soon in the second instance does tend to lead to the peaks and troughs that these graphs show."

Then just very finally, the bottom left-hand quadrant, line 17, he says:

"So the countries that were riding the rollercoaster were [I think it's supposed to be suffering] from a trifecta of large health impacts, high, long periods of stringency, and negative economic consequences ..."

So do you consider that this criticism of only implementing NPIs when it is too late, resulting in this rollercoaster approach whereby restrictions are ended too quickly only to be ramped up to maximum, is applicable to the Welsh Government's response in autumn 2020?
A. So around the firebreak?
Q. Say from September 2020 onwards.
A. So this was a phase when local area restrictions were first put in place and kind of spread -- you know,

spread around Wales and then -- and then moved to the firebreak.

I mean, I think there was certainly SAGE evidence of, you know, advice that a circuit-breaker should be implemented and, you know, I think that might have been implemented earlier in Wales. I'm not sure the extent to which, you know, the Welsh Government was, you know, trying to -- or anticipating a kind of more general move to a circuit-breaker across Britain, so that may have been one of the things that slowed down that response.

And I'm also not sure exactly how and why, you know, circuit-breakers seemed to get identified as two-week periods. It seems to me one of the critical things about a firebreak or a circuit-breaker is that you pre-announce when it's going to end, and that was a very clear feature of the firebreak in Wales, that the government seemed very strongly committed to pre-declaring what would happen afterwards, and that became mixed up with the UK Government then introducing its lockdown that wasn't called a firebreak but lasted longer, a month, but also pre-announced when it was going to end. So, you know, I think there was quite a lot of confusion there.

It's also unclear to me, you know, simply because this isn't my area of technical expertise, what -- the

relationship between that firebreak and the emergence of new variants of Covid, which came through September and then became much more prevalent in -- at the end of that year and through the next year, the so-called Kent or Alpha variant and so on.

So exactly what the mix of the causes of the significant increase in infections and deaths, you know, towards the end of 2020 and into 2021 would be, you know, I can't determine. But I think there is -- there was a sense of -- a sense that that firebreak might have been introduced earlier. There may also have been concerns about funding it as well that influenced the timing. And again, kind of referring back to a previous set of discussions, it is striking to me that when the UK Government introduced the lockdown at the end of October, beginning of November, the Treasury increased the proportion of the furlough that the government paid from 60%, which it had been in October, to 80%, you know, again apparently responding to things in England. Sorry, I'm mixing up things.

Q. I just want to ask one follow-up question to that, and it's --

LADY HALLETT: Only if it's within his expertise. I was worried, as you know, Ms Shepherd, that I shouldn't have given permission for this question because it's not

really within this witness's expertise. So, first, what's the question?

MS SHEPHERD: I was going to ask: no matter the reason for the Welsh Government implementing the firebreak when it did, was the ultimate result that Wales was in a situation where we had this ramp up, ramp down rollercoaster --

LADY HALLETT: I think, to be honest, that's more for an epidemiologist or a scientist --

MS SHEPHERD: Thank you, my Lady.

LADY HALLETT: -- as opposed to a professor of law and politics, so, I'm sorry, but I think I'm going to have to stop you there.

MS SHEPHERD: Thank you, my Lady.

LADY HALLETT: Thank you.

Thank you very much indeed, Professor. I'm sorry if we did stray beyond expertise. It's my fault, I shouldn't have given permission for that question. But thank you for your help anyway and I'm sorry we can't have a longer seminar.

THE WITNESS: Thank you.

(The witness withdrew)

MR POOLE: If I can please call Professor Sir Ian Diamond.

PROFESSOR SIR IAN DIAMOND (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2B

LADY HALLETT: Thank you for your continuing help, Professor.

THE WITNESS: It's a privilege to have the opportunity again.

MR POOLE: Could you please start, Professor, by giving us your full name.

A. Yes, I am Sir Ian Diamond and I'm the National Statistician.

Q. Now, you are in fact Professor Sir Ian Diamond. I was proposing to call you Professor Diamond, is that --

A. I am very happy for you to call me whatever you wish.

Q. Now, Professor Diamond, I think you know the drill from Module 2, but if you can keep your voice up so that we can hear you but also so that your evidence can be recorded. If I do ask you something you don't understand, please ask me to rephrase it.

Now, Professor, you have been good enough to provide a detailed witness statement for this module, Module 2B, and we can see it there on screen. You signed that statement on 8 January of this year. Is that statement true to the best of your knowledge and belief?

A. Yes, it is.

Q. You also provided two witness statements to Module 2 and you also gave evidence in Module 2 on 10 October, and the transcript of that evidence is obviously available

on the Inquiry website.

If I can start, though, with just a few questions about yourself. You are the chief executive of the UK Statistics Authority and since August 2019 you have been the National Statistician; is that right?

A. That's right.

Q. You are also head of the Government Statistical Service and Analysis Function, and in that capacity you provide, am I right, overall leadership for the Office of National Statistics and the statistics profession across the UK Government?

A. Yes, I would just clarify I'm head of the Government Statistical Service and I'm also head of the Government Analysis Function. They are two separate -- the analysis function includes the statisticians but also includes economists, operational researchers, social researchers, actuaries and geographers.

Q. I'm grateful.

If we can start, then, please, with some questions about generally data gathering in the UK but also Wales. Dealing first then with the UK Statistics Authority, what is the UK Statistics Authority?

A. The UK Statistics Authority consists of the Office for Statistics Regulation, which is the regulator of statistics, but, more importantly for this bit, the

Office for National Statistics, which is the operational arm of the UK Statistics Authority. The Office for National Statistics has a responsibility to provide official statistics across largely the economy and population and society and to produce those statistics in order to provide the evidence on which policy can be based.

Q. Can you please describe to us the way in which the UK Statistics Authority operates in relation to the UK Government but also the devolved administrations.

A. Yes, I can. With regard to the UK Government, the UK Statistics Authority is independent of government, although we do have a line to the Cabinet Office, but we are entirely independent and have a board with an independent chair, Sir Robert Chote.

Statistics is a devolved responsibility to the devolved administrations, and -- I, though, still have, you may call it a pastoral responsibility to the three chief statisticians of the devolved administration, and we meet regularly and we talk and we have a concordat between the ONS and each of the three devolved administrations where we agree to work together to provide statistics where appropriate which have comparability right across the United Kingdom.

Q. So in the case of Wales, the Chief Statistician for

Wales during the relevant period was Glyn Jones, who was then succeeded by Stephanie Howarth, who we will be hearing from a bit later on.

During the pandemic, did you have much contact with the Chief Statistician for Wales?

A. Yes, very much. I personally had contact in a number of ways, both formal, so that the Inter Administration Committee -- I know that's a mouthful -- meets quarterly, and that includes everyone, to talk. In addition we had informal contact whenever that was necessary, and we met on regular bases. I would also say that my colleagues across the Office for National Statistics had very regular meetings with colleagues in the Welsh Government; indeed, around the large Covid Infection Survey they were meeting daily to discuss results and to discuss potential analyses.

I would also say that we try very hard to produce statistics for the Welsh Government in some areas, particularly mortality. In other areas we are ready to respond to requests.

Q. Now, Professor, I'm right in saying that you attended a SAGE meeting on 16 April 2020, and the importance of understanding the R number or the reproduction number and the community prevalence for the following two to three weeks was discussed at that meeting, and you

understood that this information would be crucial information that would inform the government decision-making; that's right, isn't it?

A. Yes.

Q. Following that SAGE meeting, the ONS was commissioned to deliver the Covid-19 Infection Survey that you've just referred to. Can you just tell us, what's the importance of the Covid-19 Infection Survey?

A. At that time, colleagues may remember that test and trace was, I think the best way to say, stretched, and indeed GP services were very stretched. Therefore we did not have an accurate measure of how much Covid was in the population, what the proportion of the population was who at any moment were positive.

And that's -- as a statistician, when I was asked what one would do, I'm afraid the knee-jerk reaction is to say "Let's do a survey". And at that time it was unclear, on 16 April, whether one could do a survey, a household survey, where one could do swabs and get that level, but I felt it was possible, and my colleagues rallied round, government said "Let us do this", and so we started. We drew a sample, we recruited a large number of people. For the first three months I would have to say it was England-only, because this was a pilot, and we ran a household survey

which enabled us to estimate the degree of positivity.

With regard to this module, it was successful and so we then started to do it for Wales, and started to produce data on a weekly basis for Wales. And the logistics of going to a household, taking the swabs, then getting them to the laboratory, getting the results -- and it is not simply, I would say, a question of, if you like, ticking positive/not and then dividing by the number, there's quite a lot of statistics that goes into estimating the prevalence, and we did all that and we made estimates twice a week.

Q. Just to put some dates on that, I think I'm right in saying that the Covid infection study started April 2020?

A. Yes.

Q. But as you've just alluded to, I think field work didn't commence in Wales until late June, I think --

A. That's right.

Q. -- 29 June, and then it started producing infection data for Wales beginning of August.

Why was there that delay in respect of Wales?

A. Well, it was I would say not a delay. As I indicated in my last response, we went into a pilot initially. It wasn't clear whether people would respond, it wasn't clear that we could get the logistics right, so it was

right to do a pilot. And when it was clear that this was a successful pilot, that's when other devolved administrations decided they wished to join and Wales was the first of those.

Q. And how did that survey ensure it was able to appreciate the specific types of data that the Welsh Government would need?

A. Well, as I indicated, Welsh Government statisticians were at our daily meetings, they were also at weekly meetings that happened, and we aimed always to respond to requests. So if there was an analysis that Welsh Government statisticians wanted on that Covid Infection Survey, then either at the daily meetings or at the weekly meetings they could say "These are matters which are important to the Welsh Government we really need to get some information on them".

Q. How was information from the Covid infection study conveyed to Welsh officials? Was it through Welsh statisticians attending meetings --

A. No, no, no, formally through -- because of the importance of pace here -- I mean, at times, for example, as one moves forward, some of the Omicron variant doubling time was about two and a half days, so one couldn't wait a long time before letting government know the results. And so what we agreed with the

regulator was that we would let management information go to government, and that typically went on a Tuesday evening, although we published a couple of days later. Why did we publish a couple of days later? That's because there was still quality assurance that needed to be done and work needed to be done to really make sure that everything was fine, and to get it ready for publication. But the broad data, a slide pack of a rather large number of slides went to government right across all four administrations, went to the Welsh Government every Tuesday evening, and they then had those data to work with immediately.

Q. Now, Professor, I want to ask you some questions about ONS statistics on fatalities. Now, I appreciate, as we've said earlier, you've given evidence in Module 2 and I don't want to make you repeat everything that you've said, but there will be some people following your evidence today who won't have seen your evidence in Module 2 or be familiar with it.

By way of a very brief overview of ONS data on fatalities during the pandemic, is it right that throughout the relevant period, the period we're concerned with, there were two main published data sources available on deaths?

A. Sorry, I thought you were going to tell me what there

were.

Q. Professor --

A. I'm quite happy --

Q. Professor, perhaps if I tell you, I tell you what they are --

A. No, no, no --

Q. -- and then you tell me if I've got them right.

A. Yes.

Q. There's the daily Department for Health and Social Care Covid-19 deaths data, that's published 2 pm daily for the UK; is that --

A. That's right.

Q. And that data was drawn from NHS England, Public Health Wales, Health Protection Scotland --

A. That's right.

Q. -- and Public Health Agency in Northern Ireland.

And then the second source, ONS weekly death registrations data for England and Wales, and that was what was released every Tuesday at 9.30 am, and that related to the week --

A. Yes.

Q. -- that ended 11 days prior; have I got that right?

A. That's right. Exactly so. And the distinction is that the ONS data cover all deaths, and with all places of death, whereas initially the DHSC data were for

hospitals, first point.

The second point is that they are -- the DHSC data would be on the day the hospital was -- recorded, and so what you tended to find, and I think DHSC data are really good at very quick estimates, is that at weekends not so many are recorded so there was always, you know, a bit of a weekend gap and then ...

The ONS data for there, our data come on date of registration and we receive them and we are able then to produce them with cause of death, because the death certificate, as you will be aware, has the opportunity to write a cause of death and an underlying cause of death, and that's where we got much, almost all, of our information on Covid mortality, whether the physician registering the death recorded Covid either as the prime or underlying factor.

Q. So, Professor, which measure, the DHSC data or ONS data, would be more accurate or more helpful to understand what was happening in Wales during the --

A. Well, I think they're both -- I think they're both helpful. So during the pandemic you would be getting the DHSC data very quickly, on a daily basis. The ONS data, which I would argue have, if you like, more granularity, give more place of death and clearly more cause of death, that comes on a weekly basis, so it's

a little slower but at the same time gives you an enormous amount of information.

So I do think it is important to recognise that, you know, very often in statistics we're able to provide quick information which we are clear about what the pluses and minuses are of, while a little later you have, if you like, a much more detailed and better information. If you're happy to wait those 11 days, as most people were, then that's what I would use.

Q. Understood.

Now, the Inquiry understands that on 31 March 2020, the ONS gave an exemption to provide the DHSC with provisional data on deaths registered weekly in England and Wales. I think the idea was that that would help ministers better understand the spread of Covid-19.

Was an equivalent exemption made for provisional data to be shared with the devolved administrations? Obviously specifically --

A. Er --

Q. -- the Welsh Government.

A. Not clear and I would need to check on that.

Q. Now, before we address fatalities, can we just look at Welsh demographics as they were in 2020, and you outline in your witness statement a number of data point estimating Welsh population demographics in mid-2020.

Just before we come to those figures, can you just explain how those estimates were developed.

A. Sure. So in 2020 we were working from the 2011 census, using what we call a cohort component method to update year on year. That basically means we start with the 2011 census, we add on births, we take off deaths and we make an allowance for migration. I'd have to say that by 2020 you're about as far away from the previous census that you get. We are still very proud of those estimates, but then in 2021 we did an unbelievably good census in Wales, and so there will be a distinction between 2020 and 2021.

Q. Now turning to the actual figures, and you've set these out at paragraph 11 of your witness statement for this module, and I don't need you to turn it up, but the estimated usually resident population for Wales in mid-2020 was 3.17 million.

A. Yes.

Q. What is the importance of the "usually resident" measure for somewhere like Wales?

A. Well, put pretty simply, that doesn't include houses, for example, that are second homes. So, you know, we don't have people there. There may also be people who report that, you know, they are working or living somewhere else but maintain a house in Wales, which may

be their first house. So the "usually resident" population is one that we use a lot.

Sometimes local authorities make a point of saying "Well, actually we want to know how many services to deliver". So let us take a place like Cardiff, the number of people usually resident, shall we say, on a Sunday evening is rather different to the number of people that Cardiff has to provide services for on a Wednesday lunchtime. So the usually resident population is a clear distinction of those people who are there, not necessarily those people who will be there at different times during the day and week. And of course does not include people who are short-term visitors, eg tourists.

Q. Now, you say in your report that the median age of the population of Wales, 42.4 years, are you able to help us with how that compares to the UK as a whole?

A. Yes, it's a little older, and indeed Wales has a slightly higher proportion of people over 65, and I think that's worth saying.

Q. In terms of demographic spread, how does that compare to the rest of the UK?

A. Well, Wales -- Wales is a very heterogeneous place, so what you have around South Wales and particularly around the old mining areas north of Cardiff is a very highly

dense population and one with relatively high degrees of deprivation. On the other hand, as you go north from there or west, it becomes a very rural population. As such, you have a real mix. So that South Wales area looks not unlike, for example, the area going from Manchester across to Leeds and around, whereas the northern and western group much more like the Lake District.

Q. Professor, you have produced a number of figures also in your witness statement about Welsh economic activity. Where do those figures come from? Is that the census or the two censuses --

A. Well, partly from the census, where we're able to ask people: what do you do? (inaudible) proportion, but we also run a labour force survey, which is a very large survey which tells us about activity and inactivity, and those data we use as well.

Q. It's right to say, isn't it, that a greater percentage of usual residents aged 16 and over in Wales were economically inactive compared to those in England?

A. That's absolutely right, and again this is one of the reasons that I spent a little time a moment ago talking about the geography of Wales, a lot of that inactivity is in that area, that old industrial area to the north of Cardiff.

Q. Changing topic slightly, and talking about four nations co-operation now, if I may, at the very beginning of the pandemic, so January to early March, you say there was less immediate contact between the UK Government and the devolved administrations. Can you just explain a bit what you mean by less immediate contact.

A. Well, I think initially, as I indicated earlier, we do have good relations, but statistics is a devolved responsibility, we meet as chief statisticians quarterly, and initially the Welsh Government was -- Statistician was working on Welsh Government issues, we were much more focused into Whitehall, and it was only as things started to evolve that we said "Come on, we need to get together here and really work together".

Q. Were there any specific challenges or delays in establishing collaboration with Wales and the Chief Statistician for Wales?

A. No, no.

Q. I'd like to now move on to talk about mortality data, if I can.

If we can have, please, INQ000396876, and this is table 6. This -- as it says at the top, "Death registrations involving Covid-19, March 2020-February 2022, UK, England, Wales, Scotland and Northern Ireland and region of England".

deaths, and what one is doing there is taking the difference between the deaths that occurred and a measure of expected deaths. Now, that's the measure that you might expect to have had. And for this table what we were doing was taking the mean of the deaths in the previous -- in that week, in the previous five years. So you take the difference between the two, and of course that could be either positive or negative. If it's positive then you've got more deaths than you would have expected, and if it's negative then fewer. And in this case, we are reporting for those particular periods much higher mortality than would have been expected.

Q. If we can just see a few things from this table, England have the highest percentage excess death registrations when looking at the whole time period, and also two of the three lockdown periods. So the periods March to June 2020 and January to May 2021. That's right, isn't it?

A. Yes.

Q. This was true when looking at excess deaths using either numbers of death registrations or age-standardised mortality rates?

A. That's right.

Q. During the second lockdown, so August to December 2020,

In terms of what we can see in that table, Wales has the second highest age-standardised mortality rate of deaths involving Covid-19 144.6.

LADY HALLETT: Sorry, just before you go on, Mr Poole, can we just say, "involving Covid", does that mean Covid appears on the death certificate?

A. Yes.

LADY HALLETT: Thank you.

MR POOLE: Thank you, my Lady.

So that was greater than the UK average, which was 143.2. England slightly higher at 145. Was that difference between Wales and England would you say that's statistically significant?

A. No.

Q. On the other hand, was Wales' age-standardised mortality rate significantly higher than the rates for Scotland and Northern Ireland?

A. Yes.

Q. Now, it might help to break this information down by wave.

Could we, please, have table 13 from your Module 2 witness statement, which is INQ000271436, please. So the table straddles those pages.

What's the source of this data, Professor?

A. So what we are looking at here is what we call excess

we can see Northern Ireland had the highest percentage above average when looking at numbers of death registrations but in fact Wales had the highest percentage when looking at age-standardised mortality rates; is that right?

A. That's right.

Q. Meaning that when one controls for the age composition of Northern Ireland and Wales, Wales fared the worst during the second wave than all of the other --

A. During the second -- yeah, no, you're absolutely right. During the second wave mortality in Wales was the highest of the four administrations across the UK.

Q. If we can please look at another chart, it's INQ000412042.

This shows weekly -- excess weekly deaths in Wales. Can you perhaps describe what we can see in this chart, Professor?

A. So what this chart does is not only give you the picture of excess deaths, but, by using different shades, and in this case the blue, the blue are those deaths which involve Covid. And so what you can see, I would suggest, quite clearly, are three things: firstly, in that first wave, there was a very strong peak of deaths in April 2020, and that that peak, the excess was largely driven by Covid.

The second thing I would say, and you've just referred to it, is a very high peak in the autumn and early part -- autumn of 2020 and early part of 2021, and again that was largely driven by Covid.

The third point I would make is that following those two very, very big peaks, the numbers of deaths later on in 2021 and into 2022 do not have those peaks of excesses. While sadly there remain a number of Covid deaths marked in blue, a -- due to a number of things, improved treatment, improved -- the brilliance of vaccination and other things, the actual mortality due to Covid went down greatly while at the same time as some of the new variants, I'm thinking particularly of the Omicron variant came in, the actual proportion of the population who had Covid got very much bigger than it had ever been before.

So, if you go back to March/April 2020, the proportion of the population overall we would suggest with Covid was relatively small but if you got it, particularly if you were old or frail, then very, very sadly, the prospect of mortality was high. By the end of the period the probability of actually having Covid had increased, but due to all those factors, vaccination, better treatment, and indeed perhaps the evolution of the virus, the probability of mortality had

reduced greatly.

Q. That's very helpful, thank you, Professor.

Can we please have another chart on screen, it's INQ000412042. I think it's at page 2 of those slides.

Now, this is showing "Daily deaths with Covid-19 on the death certificate", comparing Wales and then comparing it to the UK.

What does this comparison show us, Professor?

A. Well, much, I would have to say, as what I've said previously. I would say also very clearly that we have put different Y axis scales there, so there's not a complete comparison, so don't think that the numbers in Wales were rather bigger than the numbers in England, but it's making the point, I think, very, very clearly, firstly, that the trends largely mirrored across the UK and in Wales, but secondly you really can see that big peak towards the end of 2020, beginning of 2021, which is the point we've just been making about mortality in Wales sadly being rather bigger than anywhere else during that second wave.

Q. If we can move then to talk about deaths in Wales by age, and do so by reference to another chart.

It's -- I think it's the same INQ but page 7 -- yes, I'm grateful.

This shows "Age-specific death rates involving

Covid-19 by [a] five-year age group, [in the period] March 2020 to June 2022 ...". Can you please just talk us through what we see here. What does this tell us about the age distribution of Covid-19 deaths in Wales?

A. It tells us very, very simply that mortality in Wales was very largely restricted to the elderly.

Now, we know from other places that often there were comorbidities that may have played a role in mortality for younger people. We don't see that very much. That's not to say, clearly -- there are small numbers of people aged 40-44 and 45-49 who, very sadly, would have died, but basically what this is showing is that mortality in Wales was restricted to the elderly.

Q. Now, I think you conducted your own work into excess deaths per age group and you've set this out helpfully in your witness statement and -- to show the effect of Covid on different age groups compared to deaths in non-Covid years.

Am I right if I was to summarise the work you carried out as concluding that the highest excess mortality was observed in those aged 45 to 49 years old, with age-specific rates between this period March 2020 to June 2022 being recorded as 16.8% above the five-year average?

A. I think that's right but I would have to say, and it

comes back to the point I've just made, and I'm not trying to make a statistical point but a -- if you have a very small number, then it doesn't take a very big number for that to be quite a big proportion. So yes -- and, you know, you're right, the good news is that people aged 45 to 49 do not have very high mortality, and so that small amount of mortality is a relatively high percentage. But it does not, as that graph that I've just talked to shows, become a high mortality compared to those older ages.

Q. I understand.

If we can move then away from age and focus on place -- we can have the chart, thank you, it's page 8 of the same document -- and just talk us through again what we see there, in particular, if you could, the negative figures for hospital and hospice.

A. Right, well, when we are looking here is at the excess deaths by where the death occurred, and I will come, if I may, to "Hospitals" and "Hospices", but if I could just make a point about the positive ones first.

We saw a significant increase in deaths at "Home". Now, some of that could be Covid, others of it could be, for example, cardiovascular disease or whatever, you know, where people had not gone into hospital. We also see a significant increase in care homes than we

might have expected.

And I just want to say a few words again about "Other communal establishments" and "Elsewhere", because the percentages are high, but, as the point I made earlier, they are high percentages of small numbers. And the "Other communal establishment" is a very big group which includes all kinds of things, including, for example, student halls of residence where there was no mortality or almost no mortality, but it does include sheltered housing, and that's where we think much of that increase comes, you know, where, one, again -- because people are looking after themselves, although they are very elderly, mortality there is relatively low. And the "Elsewhere", which includes all kinds of things, does include those people who were pronounced dead, sadly, on arrival at hospital. And again, we would suggest that that could include a wide range of areas, including cardiovascular disease or whatever, but, you know, sadly, that's there.

So let me then return to "Hospital". The first thing to say is that, yes, the numbers are below zero but they're tiny below zero and I might suggest, and can I just stress in what I'm about to say that I am speculating, I do not have firm evidence, but we do know that a lot of illnesses people didn't go to hospital,

for all kinds of reasons, because the hospitals were absolutely stretched doing wonderful things dealing with Covid patients, and so that could have led to just a small reduction despite the fact that we had looked at those peaks.

And very similarly with hospices, I would suggest that people were choosing perhaps to stay at home if they had, for example, sadly, terminal cancer, rather than going into hospices.

Q. Professor, in your statement -- and we can take that chart down, thank you -- in your statement you describe how there was only limited understanding of the way in which socioeconomic characteristics contributed to deaths in Wales unlike in England. Can you just start by explaining why that is.

A. Very simply, in order to make good estimates, there needs to be enough data to make estimates from, and so we did make estimates as best as we could during the -- during 2020, often linking mortality data back to the 2011 census. Now, that presents problems, because, if you think about it, many people who were in the 2011 census would have moved home, would have migrated internationally, so we had to use a number of quite complex statistical techniques to be able to make those estimates, and we were able, for example, to make some

estimates at that period around ethnicity. We were able then to make longer -- we then moved to using data that we were able to get in England from Public Health -- from GP records, and we used those for England in the future.

What that showed was a high degree of association between mortality and ethnicity and mortality and deprivation, and we see that in Wales as well, where we're able to look. And we did not do work following 2020 for Wales but we did offer to work with colleagues in Wales and offer the code to them, and the 2011 census data were made available in Wales to the SAIL Databank, and to Digital Health and Care Wales.

Q. I understand, because I think that links to a question I was going to ask. Stephanie Howarth suggests in her statement to the Inquiry that the SAIL Databank that you've just referred to has access to GP data obviously in Wales. Would that have enabled some parity between statistical publications for --

A. Yeah.

Q. -- Wales and England? Is the lack of this linked information in Wales, in your view, a significant gap in identifying and understanding socioeconomic or public health trends --

A. I do think it's as a mortality. The better you are able

to link data, the more granular the information that you can get, and the better that information is.

Q. What have you been able to measure to gain an understanding of sociodemographic trends in Wales?

A. Well, we were able to look at geography, and I think it is important to note that the areas with the highest levels of mortality, Rhondda Cynon Taf, Merthyr Tydfil, are those areas where one would find associations with deprivation and to something you mentioned earlier, inactivity, which could be due to ill health. So we're able to say that.

We did find some early data around ethnicity, and we were also able to look at what is called the Index of Multiple Deprivation. Now, this is an index which is put together from a large number of variables, typically those in censuses, and which is able to go to a relatively small geography, and one is able to then -- what one typically does is take the five quintiles, and, say -- let's go from the areas of most deprivation to the areas of least deprivation, and what we're able to say is that there is a clear gradient, a clear gradient, between the most deprived and the least deprived areas in terms of mortality.

Q. Do you have any other breakdown of deaths by, say, religion, disability status or occupation --

A. No.
Q. -- group?
A. I would say -- just a point I would make is that my colleagues would say that they can see no real reason for some of the things in those areas that we found in England not translating across to Wales, but it would be for the Welsh Government to have done that work.
Q. I think, just to illustrate a point you've made, if we can have, please, INQ000396876, it's figure 5, from your witness statement to this module. This shows proportion of excess deaths by local authorities in Wales. Does that largely accord with your findings about deprived quintiles --
A. Yes.
Q. -- that you've just referred to?
A. I mean, as I say, these are local authorities, so if you look at somewhere -- I mean, given it's just down the road, Newport, there are some pretty poor areas in Newport, but there are also some less poor areas. So overall if you look at Newport it looks like it's in the middle. On the other hand a place like Merthyr Tydfil is much more uniformly deprived.
And so I think it is important when you look at local authorities to understand that the heterogeneity in terms of deprivation across those local authorities

so that -- you know.
And it is also the case, I mean, there was no question at all, that places like Powys have very -- relatively low areas, but let us not pretend that there is not deprivation in rural areas, it's just it can be hidden compared with urban areas.
Q. Understood.
I want to move away from mortality data and talk a bit about infections data. And we touched upon this when we were talking about the Covid-19 Infection Survey, and remembering then that that only began to publish data for Wales in August 2020.
Can we, please, have INQ000412042 on display. Thank you.
Professor, can you just talk us through what this chart shows.
A. What it shows is the percentage of the overall population of the four administrations who tested positive in any period. Note the four arrows to the left-hand side which indicate, as you've rightly pointed out, when each administration started to collect data. So what you clearly see is an increase in positivity in the autumn of 2020 -- and I don't know, sir, if we're going to discuss the firebreak at any time?
Q. By all means. I mean, this accords with the firebreak

of --
A. Yes, sorry --
Q. -- September 2020 --
A. For what it's worth I will just add it. I didn't know if you wanted to address it later.
You can see for Wales that the percentage goes up and then goes down again and then goes up again, and that accords with the firebreak that the Welsh Government brought in.
Things then flatten off in the early summer of 2021. There is then an increase. And then in late 2021, when the Omicron epidemic came strongly in towards -- that you actually see the highest percentages that we have seen.
And I would point out that, again, these are national data, and if you were to look at the age-specific numbers, which have higher confidence intervals around them, you do at times get above 10% of the population in some age groups at that time testing positive.
Of course, as I've indicated earlier, that has less of an impact on mortality thanks to the brilliance of vaccination and also better treatment, but once you've got very, very high proportions of people who are testing positive and therefore out of work, you are

actually starting -- or not able to work for that period, you are actually starting to have enormous impacts on the economy, and that is something I think that we need to remember in that latter period.
Q. Thank you, Professor.
And we can take that chart down, please.
The Covid-19 Infection Survey was, I think I'm right in saying, able to generate data about likelihood to become infected based on some sociodemographic characteristics; is that right?
A. That's right.
Q. But that data was UK-wide data rather than Wales-only data; is that correct?
A. That's right.
Q. Can we please have another chart displayed. It's INQ000396876. It's -- thank you, yes. It's that figure 10:
"Likelihood of testing positive for Covid-19 by core demographic characteristic, UK, 29 August to 11 September 2021."
Again, Professor, perhaps you can just talk us through what this chart shows us.
A. Well, what it shows, and it comes back to many of the points that I've been making, and that is that if you are in a larger household, the probability of testing

positive increases. If you are in a more deprived area, the probability of -- well, this graph shows the lower the deprivation, the lower the rate. The opposite of that, clearly, for higher deprivation. Also shows that the major -- the big urban areas and, indeed, the slightly less big urban areas had higher probabilities. And it also shows that there is a variation but very little difference in terms of the probability of being positive between non-white populations as a whole, people of colour, and the white population.

Q. I was going to move on to ethnicity data. Are estimates able to be produced for mortality in Wales across ethnic groups?

A. We have produced them for 2020. I'd have to say the numbers of people of colour, broadly defined, are in single figures, and so it would be very hard to make any strong assumptions and we have not done it post 2020. You'd need to talk to Stephanie Howarth about that.

We have shown for -- in that period for England and Wales, that there were strong differences by ethnicity of mortality. And we would argue for a number of reasons that -- we cannot hide from the fact that in our country people of colour are more likely to live in deprived areas, are more likely to be in multigenerational households, all the kind of things --

and are also less likely to be in occupations which enable them to work from home, and all those reasons would have contributed to those factors.

Q. I was talking about mortality just then, but what about infectiousness in Wales, were estimates able to be produced for infectiousness across ethnic groups?

A. No, well, we found that very difficult and we tried in many ways. The reason for that is while we've got quite a number of people in our sample, the proportions positive are often very small, and so actually trying to fit strong models becomes very, very difficult because you've got very, very small numbers of people who were positive.

So, you know, you've got -- you know, once you start getting sort of very tiny numbers of people in different socioeconomic groups, for example, you can't actually model, so we just produce individual data and we suggest that many of the things we find for the UK as a whole would hold in the four nations.

Q. So is -- does that explain why that -- it could be done, for example, for England, but it --

A. Yes.

Q. -- couldn't be done for Wales?

A. The sample size -- I mean, these kinds of statistical models are driven by how much data you've got, and the

sample size in England was extremely big, the sample size in Wales -- and remember that it's not just the sample size but the proportion testing positive means that you're actually working with relatively small numbers, and that makes estimating some of the models almost impossible.

Q. Now, data gaps, Professor, were identified for those with protected characteristics in Wales by the Equality and Human Rights Commission's 2018 paper *"Is Wales Fairer?"* Are you aware of that report and its finding on this question of data inequalities for --

A. I'm aware it talks about disability.

Q. A point to note, I mean, moving to -- that was a 2018 paper. Moving forward two years, during the pandemic there were no datasets -- or no datasets that permitted any meaningful comparison were available for the impact of the pandemic on ethnicity, occupation, religion, disability status; that's right isn't it?

A. I mean, disability, I would have to say, is a major data gap for our country. And we do have a question on the census which asks about limiting long-term illness, and that gives you some information but it doesn't actually help, in terms of the granularity, as to whether you might have -- be hard of hearing or whether you have musculoskeletal problems.

So we do, I believe, have a data gap around disability, and indeed we at the ONS have been trying to engender some conversations about that.

Q. What actions did the ONS take to support the Welsh Government assess the unequal impact of the pandemic?

A. We offered support at any time. We offered at different times to share some of the code that we had developed. And, as I indicated, we enabled the census data to be in Wales and we have the Covid Infection Survey data which were held in our Secure Research Service, and Welsh statisticians were able to access those data very easily and very quickly.

Q. Now, a point that we touched on yesterday with Professor Ogbonna, would it assist if ethnicity data was recorded by coroners and registrars on death certificates?

A. I'm not completely convinced about that. And the reason I am not convinced about it -- let me start by saying I'm 100% convinced that we need to get mortality by ethnicity, but the point I would make is that when one gets to the death certificate, the person who most knows about their ethnicity is sadly no longer with us. Which is fine, you know, if it is a very close relative who is reporting, but it doesn't necessarily need to be that.

So I'm personally not convinced about putting ever

more data onto death certificates. What I would prefer to see is that we had a system, for example through the health service, which routinely collected good ethnic data and where we committed on a very regular basis to link those data together, and to be able to publish differentials in mortality by ethnicity.

So I'm -- let me be clear, I'm 100% convinced about the need to produce more -- you know, I'm not just -- I would suggest ethnicity, I would also add disability or add other areas. But I would argue the best way to do it is through having those data available through, for example, the health service and then linking them in. Which we can do very easily and very quickly.

Q. Did you or your colleagues at the ONS collect any data from Wales on Long Covid, Professor?

A. Yes, we did. And it is self-reported, and again one of the advantages, I would argue, of the Covid Infection Survey that we've talked about thus far during this morning's conversation is that it was longitudinal in nature. What does that mean? That means that we go back to the same households over time. That enables us to follow up and to ask people: have you still got the symptoms? And what are the symptoms? And that enabled us to make overall estimates for Wales. And to answer perhaps your following question "Could you get down to

socio-economic groups?", no. But, we were able to identify levels of Long Covid self-reported, and that peaked at 4%. 4%. One in 25 people reporting that they had experienced Long Covid, and that's self-report, ie "I'd had symptoms for at least 12 weeks", and in some cases for a year.

Q. The Inquiry understands that information was requested from Number 10 about Long Covid in February 2021 and from that point the ONS provided updates at DHSC ministerial round tables on Long Covid. Has the Welsh Government made a comparable request?

A. I'm not clear whether there was a request -- there was certainly -- I'm not aware of a request formally to me. But as I indicated right at the beginning, statisticians in the ONS were meeting on a very regular basis with statisticians in Wales, and those conversations regularly included discussions about analyses, which would have been asked for.

And indeed I think the other thing to say about the Long Covid is that we were able to make some small disaggregations and to say that Long Covid was more likely to occur amongst women and also amongst those in the more deprived areas.

Q. Professor, just returning to a topic we touched on earlier, about collaboration with ONS and Welsh

Government, and we can see from your statement that UKSA and the ONS worked closely with scientific and expert groups within the UK Government, and at paragraph 153 of your witness statement you state that your engagement with scientific and expert groups in the devolved administrations was much more limited. Briefly, why do you think your engagement was more limited with those groups in the devolved administrations?

A. Well, I mean, very simply, because we, if you like, were not able to just say "We're coming". And so, yes, we did go and present to the Technical Advisory Cell of the Welsh Government, and we did have conversation, but we are waiting, in many cases, to be asked, whereas with the UK Government you know, I was part of SAGE, I was -- as indeed were colleagues from the Welsh Government. I would have to say that also particularly the chief data officer of Public Health Wales, a woman called Fliss Bennee, attended them of the same meetings that I attended, with, for example, the Joint Biosecurity Centre and all kinds of things. So the Welsh were at many of the meetings. But we only attended, for example, the Technical Advisory Cell when invited.

Q. Professor, just finally then, from me, we heard evidence yesterday from Helena Herklots CBE that deaths of people in care homes were not counted early in the pandemic.

This might well be a question for Stephanie Howarth rather than you, but are you aware of why those deaths weren't counted in Wales?

A. No. We were able to do, as -- I mean, we've looked at the data that I've shown you already, and we do get place of occurrence. What I can't tell you is why they weren't counted initially.

MR POOLE: Professor, thank you, they're all the questions I have for you.

THE WITNESS: Thank you.

LADY HALLETT: Thank you, Mr Poole.

I think we have some pre-approved Rule 10s. I think it's Ms Gowman.

Questions from MS GOWMAN

MS GOWMAN: Thank you, my Lady.

Professor, I ask questions on behalf of Covid-19 Bereaved Families for Justice Cymru.

My first question relates to the data available to SAGE to inform its advice, and indeed you've confirmed in your evidence that you were part of SAGE. Do you agree with the evidence of Professor Ailsa Henderson in Module 2 that, firstly, SAGE focused overwhelmingly on data from England, and, secondly, that sometimes data from England was described as UK data for the purpose of SAGE advice?

A. I would have to say that I would agree that a lot of the data which were looked at were England-centric. I would also, though, say that Welsh, Scottish and Northern Irish colleagues were at every SAGE meeting, and on very many occasions I can recall Sir Patrick Vallance making an effort specifically to bring in those colleagues to ask ... and as I said before, the Welsh Government did have a Technical Advisory Cell and we presented to that cell when invited.

Q. But focusing specifically on SAGE, and you've accepted candidly that SAGE did seemingly focus on data from England, but you've rightly pointed out that there was attempts to draw in data from Wales, what was the breakdown between English-centric focus and the attempts made to bring in Welsh data? Where did it go --

A. Well, I think -- I mean, I think -- I mean, just for absolute clarity, I didn't say that it was totally English-centric --

Q. No --

A. -- I did say --

Q. Yes.

A. And I would also say that much of the modelling that went on used the Covid Infection Survey that I've had the privilege to talk about this morning. And that's

UK-wide. So much of the data on which, for example, the mathematical models were used, was based on UK-wide data and therefore included Wales.

So I wouldn't -- I would not like, with respect, to put a percentage on things. I am conscious that Welsh colleagues, Scottish colleagues, Northern Irish colleagues, had every opportunity to input and that much of the modelling that went on would have used UK-wide data.

Q. Thank you.

Moving on to my next question, and for context, the Welsh Government liaised with the UK Government to provide daily aggregate data to feed into the UK Government's Covid-19 dashboard, and with that in mind, do you agree with concerns raised by some in Welsh Government, for example former Chief Statistician Glyn Jones, that "definitions of data items were not always clear at the outset" and that this "posed a risk of misinterpretation by assuming data across four nations comparable" when that was not always the case?

A. I don't think there was -- actually I disagree with -- Glyn Jones is someone I respect enormously. I think -- look, initially there were different definitions. I have no doubt about that. And indeed I got a group together in, I recall, June, I think it was June, but in

the summer of 2020, said, "Look, we need across our four administrations, we need a very clear definition", and there were different definitions and I brought that together and I made it happen. Previous to that, you know, it may be that people misinterpreted, but, you know, typically the footnotes would have been -- made it very clear what those data were.

I do think, and I've said this many, many times, very early on in the pandemic there were a lot of data moving around and I don't think always that the visualisation of those data was absolutely brilliant, and we worked -- we being ONS and many others -- worked very hard to move from what I would call a data deluge into insight by moving to really ask questions.

I mean, this morning has been an absolutely fine example of that, where you can -- you get some really good questions and you can say what the data says about them. And that I think was something that happened very quickly, but early -- you know, in February/March, early April 2020, there were a lot of data around, which was one of the reasons we started the survey.

Q. And something that we can learn moving forward --

A. I think it's a real lessons learned. I mean, I do try to address in my witness statement some lessons learned. I do think that whoever -- I mean, I very much hope

there isn't another pandemic like this, but I do believe that the National Statistician should be right at the heart very, very early. I do believe that we need to make sure we are sharing data much more easily and much more quickly. And indeed I do believe we should be sharing those data now so that we are ready. And I do believe we need very much to be learning.

Perhaps, I mean, you and your colleague who talked before would not need to learn this, but I think sometimes it is the question that we need to make sure we are asking questions. If you just came to tell me something interesting about whatever, I might tell you something interesting but it might not be the answer you needed. So really focusing on questions and learning to focus on questions is something that we, as a nation, need to improve in our data literacy.

Q. Thank you, Professor.

Very, very briefly, one final question on the Covid-19 latest insights tool that you've already mentioned. Did that tool incorporate data from Wales and analysis specific to Wales?

A. Yes, it did, where -- in those datasets which were UK-wide.

Q. I'm grateful.

A. So Covid Infection Survey, Opinions and Lifestyle

Survey, designed UK-wide, able to produce data which would include Wales.
Q. And more specific because it was answering questions, as you put it?
A. 100%.
MS GOWMAN: Thank you, Professor --
THE WITNESS: Thank you very much.
MS GOWMAN: Thank you, my Lady.
LADY HALLETT: Thank you very much, Ms Gowman. I think there were suggested possible extra questions, but I have been told what they were, and one of them I think, about infection surveys in schools, could be asked of the next witness, because it's a Welsh-specific question, and I think the other question that I have been told about I'm afraid is not for this witness who is not an expert in public health, so there are no further questions.
Thank you very much indeed, Professor, I'm very grateful. I'm not going to give you a guarantee I'm not going to ask you again to help, but --
THE WITNESS: Were you to ask me again, let me be very clear, it is a privilege to be able to --
LADY HALLETT: Very kind of you to say so. Thank you very much indeed.
THE WITNESS: Thank you very much.

Thank you very much.
(The witness withdrew)
LADY HALLETT: What time is it? 1.55.
(12.54 pm)
(The short adjournment)
(1.55 pm)
LADY HALLETT: Right.
MS SPECTOR: My Lady, please can I call Stephanie Howarth.
LADY HALLETT: Thank you.
MS STEPHANIE HOWARTH (affirmed)
Questions from COUNSEL TO THE INQUIRY
MS SPECTOR: Please could you give us your full name.
A. I'm Stephanie Howarth.
Q. Ms Howarth, thank you for attending today and assisting the Inquiry. Whilst you give your evidence, could you, please, try to keep your voice up. This assists people who are listening here but also helps the stenographer who is making a note of the proceedings. If I ask you anything that isn't clear please just ask me to repeat.
You were asked by the Inquiry to provide a witness statement addressing your role as Chief Statistician for Wales, and we can see the statement that you were good enough to provide on screen before you. Now, you signed this statement on 15 January 2024. Is that true to the best of your knowledge and belief?

A. It is.
Q. If we could please start with a few questions about yourself. You are the Chief Statistician and head of profession for statistics in the Welsh Government, and that's a role that you have held since July 2020?
A. That's correct.
Q. What are your responsibilities in that role?
A. So as the Chief Statistician I am the Welsh Government's principal adviser on official statistics. I oversee the independent production of official statistics in the Welsh Government. I also have a role as head of profession then in building the statistical capability and capacity within the Welsh Government, and I oversee the implementation of the code of practice for statistics.
Q. Is it right that you remain operationally independent in terms of decision-making around official statistics?
A. That's correct, yes.
Q. Now, we'll come to hear more about its work in due course, but does the Knowledge and Analytical Services, or KAS, within the Welsh Government sit within your directorate?
A. It does. So Knowledge and Analytical Services is made up of two parts and the statistics part is the section that I lead.

Q. Now, you have seen the statement that Glyn Jones has provided to the Inquiry on behalf of KAS dated 8 December 2023. Do you agree with the contents of that statement?
A. I do.
Q. So moving to KAS now, please can you briefly outline what KAS is and what its role is within the Welsh Government.
A. So KAS is Knowledge and Analytical Services. It's a part of the Welsh Government that brings together the analytical professions, so statisticians, social researchers, economists, to provide analytical evidence and advice for Welsh Government ministers and officials to enable them to do their roles.
Q. To broadly summarise the work that KAS did during the Covid-19 pandemic, is it correct that it established new data collections, acquired data from other bodies and third party organisations, provided analysis and advice to ministers and officials on Covid data, including the compilation of weekly data monitors, published and communicated regular Covid-19 statistics, and contributed to the work of TAC, TAG, Public Health Wales and Digital Health and Care Wales on statistical matters?
A. That's correct, and also we maintained a range of our

regular statistical publications as well, that might not have been specifically about Covid-19 but were still important to understanding what was happening in Wales.

Q. Ms Howarth, is it right that prior to the first national lockdown, neither the Chief Statistician nor KAS, in general, were actively involved in reporting on or briefing on the spread of Covid-19 as this was being led by Public Health Wales and by TAC?

A. That's broadly correct. So from the start of March Knowledge and Analytical Services had started to become more involved in work around Covid-19, but most of this work, in terms of reporting on things like infection levels and deaths, was being led by Public Health Wales.

Q. I'm now going to ask you some questions about the data compilations that were provided by KAS during the pandemic. Was the assembly of statistical information about Covid-19 a key strategic priority for KAS for the Welsh Government at the outset and during the pandemic?

A. That was certainly one of our main responsibilities. And bringing together the wide range of data that was in circulation was a key responsibility of KAS, to bring all that into one place.

Q. And one such repository of key data or key information for the Welsh Government was the Covid-19 analysis hub which was stood up on 23 March 2020; is that right?

A. Yes.

Q. Initially the hub published all new data related to Covid-19 cases and deaths, and this was then later progressed to topics such as care homes, testing and contact tracing; is that right?

A. Broadly. So Public Health Wales led on the publication of rapid surveillance data around cases and deaths and ONS then on deaths data from death certificates. But the hub had a role in re-using that information and bringing it together for use within the Welsh Government.

Q. How frequently was the data on the hub updated?

A. It would really vary by source. So there was a range of data sources that we were using, some of these were daily so we would use the daily information that was coming from Public Health Wales on things like the number of cases and the number of deaths. There was also daily information around school attendance and the number of people in hospitals, but some other sources would be less regular, might be weekly. So, for example, some data around testing and contact tracing, those things tended to be slightly less regular than daily, but still much more frequent than we might have been used to prior to the pandemic.

Q. Coming slightly later in the chronology was the Covid-19

data monitor, which I understand was produced on 3 April 2020. Ms Howarth, how was that different to the hub?

A. So the hub was a structure, a team essentially, within Knowledge and Analytical Services that was co-ordinating the role of statistics in the pandemic. The monitor was one of the products that the hub produced, and it was a compendium of statistical information about the pandemic, so that that information was there in one document and could easily capture the trends around Covid-19 and its associated harms in Wales.

Q. You've alluded to it already but am I right in saying that Public Health Wales also published their own weekly Covid-19 data, including their Covid-19 data dashboard, which was circulated around senior Welsh Government officials and ministers?

A. So Public Health Wales would publish daily information on their dashboard around cases and deaths and testing. The Welsh Government -- if we're talking about the data monitor here, this wasn't something that was initially published, this was something that was circulated within the Welsh Government, although in time it did become a public-facing document.

LADY HALLETT: Can I just interrupt to say that I'm afraid you've both got the same failing I have, which is

speaking very quickly.

MS SPECTOR: Yes, please do remind me of that as we go through.

LADY HALLETT: I'm afraid it's something I have to remind myself of on occasion. Thank you.

MS SPECTOR: Thank you, my Lady.

By April 2020, if I were, say, a senior government official and I wanted to understand what was happening in hospitals, is it right that I could check the data monitor published by KAS or the Public Health Wales weekly dashboard or any of the other publicly available information from, say, the ONS?

A. So for information about hospitals, that was broadly made available within the Welsh Government, so the data monitor would have been one of the main ways that we circulated that information.

Q. Please can we have on screen INQ000271847.

This is the HSSG response to Covid-19 lessons learned document produced in August of 2020.

Ms Howarth, am I right in saying that KAS contributed to that lessons learned report?

A. Yes.

Q. If you look, please, at page 3, in the middle of the column, penultimate paragraph:

"Not always clear cut split in responsibilities

within KAS between health stats and covid hub."

In the next paragraph:

"Multitude of dashboards being prepared for different purposes sometimes with similar but slightly different data flows. In terms of [Public Health Wales], this was sometimes done without any regard to what else was happening in the system. This then leads to duplication of similar outputs between [Public Health Wales] and [Welsh Government]. Creates confusion in the media and the public."

Was that a fair criticism of the way in which data was presented during the first wave?

A. I think it's certainly fair to say that data was available from multiple places, and part of the reason for bringing a product like the data monitor together, and eventually then publishing it, was to have one place that brought together all the key information. But that being said, there were times, and I think that's what this information is referring to, where new things would be published by other organisations, for example Public Health Wales, that we weren't necessarily aware of in the Welsh Government that were going to happen, which I guess was a missed opportunity to co-ordinate better and think about presenting one collective message so that you could avoid that potential confusion.

Q. I'm now going to change topic and ask you about NHS management information. We will hear during the course of this module that hospital information was a key part of pandemic response and informed Welsh Government decision-making. Focusing on the early days of the pandemic and the first wave in particular, was data on hospital admissions to intensive care and admissions in general a critical dataset for Welsh Government decision-makers during that time?

A. It was certainly one of the datasets that was used a lot and very significantly, yes.

Q. We heard this from Professor Sir Ian Diamond this morning, but at that time there was no mass programme of community testing, meaning that hospital admissions was crucial for the government to understand the spread of Covid-19 in communities; is that right?

A. Yes.

Q. It's understood that KAS received data from hospitals on admissions due to Covid-19, patients in hospital suffering from Covid-19, bed capacity, ICU capacity, ventilator figures and so forth. Is that right?

A. Yes. Actually, can I just clarify? So we were one user of that data, so the data was collected by Digital Health and Care Wales and it was provided to the Welsh Government. Initially it was provided to the NHS

performance team, which is part of the health policy area, but KAS was also a team that used that data. So it wasn't coming directly into KAS.

Q. We'll look at some charts based on the data that was provided in due course but before then I want to ask, if I may, about some of the limitations of the KAS data received from health boards during the first wave.

First, the Inquiry understands that there were issues with precisely what was measured and what could be measured in hospitals. Andrew Nelson, the chief information officer at Cym Taf Morgannwg University health board, has highlighted the following three issues, and I'll read those out.

Number one, before 24 March 2020 it was difficult for health boards to even work out the number of admissions to hospital due to Covid-19 as this was dependent on mining free text fields from the emergency department datasets, which would have been prone to error.

Number two, there was no data differentiating community-acquired infections from hospital-acquired infections, meaning that the case load of Covid-19 in the community could be overestimated or it could be underestimated.

And number three, data did not distinguish between

the numbers of patients admitted due to Covid-19 compared to the numbers admitted for a different reason but who happened to have Covid-19.

LADY HALLETT: Pause. The transcript is not running, I don't know if it's just mine or whether it's because -- no, it is back. I think it's because you were speaking too quickly, Ms Spector.

So we have -- the last one the [draft] transcript's got recorded "... it was difficult for health boards to even work out the number of admissions to hospital due to Covid-19 ..." and there we stop. So that was number one.

So can we finish number one and then go back to the others, please? Sorry about this.

MS SPECTOR: Madam, I think that might have been number three.

LADY HALLETT: No, I think that was --

MS SPECTOR: For ease, I'll go through all of them once again. Thank you, my Lady.

Number one, before 24 March 2020 it was difficult for health boards to even work out the number of admissions to hospital due to Covid-19 as this was dependent on mining free text fields from the emergency department datasets, which would have been prone to error.

Number two, there was no data differentiating community-acquired infections from hospital-acquired infections, meaning that the case load of Covid-19 in the community could be overestimated or underestimated.

Number three, data did not distinguish between the numbers of patients admitted due to Covid-19 compared to the numbers admitted for a different reason but who happened to have Covid-19.

Do you agree with the issues that Andrew Nelson has identified?

A. Broadly, but I think there's probably some nuance to some of those. So the second point, around hospital-acquired and community-acquired Covid-19, I know Public Health Wales did publish information around hospital-acquired Covid-19. And then the final point was around, I think, those who were in hospital for Covid-19 reasons and those who had incidental Covid, for want of a better term, from I think it was January 2022, so relatively late on. There was information available that made that distinction, but certainly for the majority of the pandemic that wasn't in place.

Q. Is it fair to say that each one of those issues had the potential to make healthcare data in the first wave less reliable for policymakers?

A. I'm not a policymaker so I can't necessarily comment on how the information was used for policymaking purposes, but I think there's a couple of points here that -- there was a range of statistical information. So you have things like the testing data, the hospitalisation data and the mortality data, and those things collectively tell you about the trends of what was happening in Covid-19. But then I guess what -- was it Mr Nelson who made this statement? I think the point that he's making here as well is about the underlying health data systems within Wales and that they perhaps do not offer the flexibility to collect information in new and changing ways, and that's a point I would agree with. Some of these kind of legacy data systems potentially made that more challenging to do at pace.

Q. Moving on from data gathering to data reporting. In a review that was undertaken by the Welsh Government in April of 2020 a number of matters were identified.

Please can we have that document on screen, INQ000066087, for those following.

It's titled "Review of mechanisms for reporting Covid-19 deaths in Wales".

If we look at page 1, paragraph 6:

"Following the identification on April 23rd of 84 deaths that had [now] been reported to Public Health

by" --

LADY HALLETT: "Had not been reported".

MS SPECTOR: "... that had not been reported [my apologies] to Public Health Wales by Betsi Cadwaladr University health board ... [Public Health Wales] and Welsh Government officials have sought assurances from across health boards and trusts concerning the robustness of the current process."

Then if we move to under the heading "Inconsistent approaches across Health Boards" at paragraph 11, on page 2:

"For example, as a result of not using a single system, [Public Health Wales] have reported a number of generic issues during the past few weeks which include: delays by health boards in the reporting of deaths; reported ambiguity in the definition of what constitutes a death to be reported through surveillance and the inclusion of deaths occurring outside of a hospital."

Then finally, under the heading "Multiple reporting streams and unclear reconciliation processes", thank you:

"Health Boards are required to report data to a number of different organisations: [Public Health Wales], internal briefings to the Board and key local stakeholders, to the NHS Wales Informatics Service ...

and to the Office of National Statistics ... These reports have different purposes and often a different basis, which can lead to inconsistency in the results being produced."

Did KAS review and agree with each of those findings at the time that this report was produced?

A. So this report was prior to me becoming Chief Statistician so it wasn't something that I was directly involved in, so this was the previous Chief Statistician who led on this work, but my understanding is that he was involved in developing this report and so, I expect, would likely have agreed with those statements.

Q. Please can we now look at, again, the HSSG lessons learned review document at INQ000271847, and the final paragraph in the central column of page 2:

"The issues that arose in mortality surveillance are well documented in the review but could have been avoided by greater roles and responsibilities and adherence to some principles around management of administrative data which KAS could have advised on. There was a lack of clarity on who was reviewing the mortality data and ensuring LHBs were submitting surveillance data."

Ms Howarth, do you accept that finding, that KAS

could have done more in those early days to ensure the quality and consistency of hospital data?

A. So I think the point that this is making is about not hospital data but about mortality data, which was being collected through the rapid surveillance measures that Public Health Wales had put in place, so this wasn't something that KAS were directly involved in, but it's making the point that the types of quality assurance processes that we use within Knowledge and Analytical Services, these approaches, if we'd been asked to advise on it, would have avoided those kind of errors and that missed reporting happening.

It's fair to say that in Public Health Wales they didn't have government statisticians with the same kind of experience and background that we have in Knowledge and Analytical Services, and if they had they might have had greater awareness of the kind of toolkits that we use around the quality assurance of administrative data that might have better helped identify that some of these returns were not being made from some health boards on that rapid mortality surveillance.

LADY HALLETT: On what basis do you work? Do you have to wait to be asked to provide a report or to analyse data or can you do something off your own bat?

A. So do you mean in terms of working with Public Health

Wales or more generally?

LADY HALLETT: Yes.

A. So I have a role as a -- kind of a leadership role across the official statistics system but generally it would be that people might come and ask for our advice on particular topics, and that has happened on regular occasions. But throughout the pandemic it was perhaps more that we were proactive in giving that advice because of the lack of experience, I guess, in Public Health Wales in using the code of practice of statistics, for example.

LADY HALLETT: So during the pandemic you became proactive but generally you would wait for the statistician at Public -- or statisticians, I can never say the word, at Public Health Wales to come to you and ask for help, advice?

A. In normal times, yes. We do have a regular six-monthly get-together of all the official statistics producers in Wales, which is an opportunity to understand what each other is working on in normal times. So yes, normally we would expect lead officials in each organisation to raise issues with the Chief Statistician.

LADY HALLETT: I'm sorry to take you back to right at the beginning -- I'm sorry about this, Ms Spector, I'm sorry to interrupt -- but when -- you didn't get involved

until the first lockdown, so the Public Health Wales statisticians were doing the work at that stage. Do you think it might have been helpful if you had been -- if your department had been asked for its assistance earlier on?

A. Potentially. I mean, the role of reporting public health statistics is a role for Public Health Wales, but I think this experience has shown that -- the value that government statisticians can bring in terms of both the quality assurance of data and the ability to communicate that data as well, and understand user needs, and I think that there was potentially an opportunity that we could have got involved earlier, yeah.

LADY HALLETT: Thank you. Sorry to interrupt.

MS SPECTOR: Not at all, my Lady.

I'm now going to ask about a different aspect of Wales' healthcare data management.

The Inquiry understands that Wales occupies a unique position within the UK due to its Secure Anonymised Information Linkage (SAIL) Databank; is that right?

A. Yes.

Q. To begin, can you explain what that databank is and what it does?

A. Certainly, so the SAIL Databank is run by Swansea University. It's what's known as a trusted

research environment. So it's a secure virtual environment where data can be deposited and researchers can apply to use that data for public good research purposes. And the thing that's particularly unique about the SAIL Databank is that all these different data sources can be linked together in a secure and anonymised way so you can learn more about a particular topic than you can from using any of those individual datasets in isolation.

Q. So the value is as much in the linking as it is in the collection of that data?

A. Yes, definitely.

Q. The Inquiry understands that during the pandemic many relevant datasets were supplied to SAIL to enable them to be linked, including data relating to social care workers, children's attendance at schools, emergency department datasets, data from healthcare workers, risk assessments and the ZOE symptom tracker app; is that right, by way of example?

A. Yes, I believe so. Not all of those would have come from the Welsh Government but that's the kind of data that would be available in SAIL, yes.

Q. Was KAS and TAC able to use this kind of data linking to support analytical work required in the pandemic response?

A. Yes, it was used considerably.
Q. What kind of work was able to be done with it?
A. So there would be work carried out either by analysts based in the Welsh Government or through the academic community as well. We brought together this One Wales partnership, it was called, which was looking to bring together those with relevant experience in this area to support the pandemic.

Some examples of the kind of work that my team did were things like linking together the shielded persons list with other data sources like the school workforce census, for example. So that could tell us about the number of teachers and school staff who were on that shielded list, which you can then use to help inform planning for return to school.

Q. For our purposes today, I want to look at the work SAIL was and perhaps was not able to do concerning Covid-19 datasets and some protected characteristics.

The former Chief Statistician Glyn Jones said in his statement to the Inquiry:

"A key challenge identified early on was the quality of data held by the NHS on ethnicity and the availability of Covid mortality data by ethnicity."

Do you agree with what he has said in his statement?
A. Yes.

Q. To run through some of the challenges that he describes:

Data on ethnicity is not recorded on death certificates in England and Wales. We've heard about that already.

Many healthcare records do not record the ethnicity of the patient.

Initial reporting of Covid-19 deaths in confirmed hospital cases through the Welsh Clinical Portal surveillance form did not record ethnicity before May 2020.

And then there's the *"Is Wales Fairer?"* report in 2018 which had already commented on the clear gaps in the data in Wales on protected characteristics. Is all of that correct?
A. Yes, that's correct.
Q. What all of this meant in practice was that the data we've described on hospital admissions, on ICU admissions, deaths relating to Covid and so forth, none of that could be grouped by protected characteristics like ethnicity; is that right?
A. Some of it could be but there would be some weaknesses in the data, and that's where the acquisition of the 2011 census was so valuable. So the former Chief Statistician had made the case for that to be deposited in SAIL because it was so valuable in

improving coverage of things like ethnicity within that dataset. So, as an example, I think I recall a colleague saying that it improved missingness within the ethnicity dataset from around 30% missingness to 10% missingness. So you've still got some records that do not have ethnicity data within them but considerably fewer than prior to bringing in the census data.
Q. If that's the census data, moving on from that, the evidence that the Inquiry has heard is that England has significantly more detailed information on ethnicity in other socioeconomic categories to link to Covid-19 outcomes, as much of this had been taken from English GP records. Now we've heard that Wales had the benefit of the SAIL Databank, why could this be done in England and could not be done in Wales?
A. I'm not sure I'd agree with that because I think GP data is available within SAIL and a range of other datasets as well which bring together a whole range of different characteristics. That's a very strong position in Wales, that we've had all this data available to link for a number of years. I think perhaps the question here is about where that data is held in different places.

So I know Ian Diamond talked earlier about not being able to carry out specific pieces of analysis within ONS

because ONS didn't hold that data but that data did exist in SAIL and it's more that ONS hadn't used the data in SAIL. It wasn't that it didn't exist in a linked format in some way. So ONS only had access itself to information about England.
Q. So in summary, it was more of an access issue rather than not having a data or having not linked the data?
A. Yes.
LADY HALLETT: I'm sorry, I'm not following. Ms Spector's question was: why is it England had better ethnicity data than Wales? Is that right, was that the question?
MS SPECTOR: My Lady, the question was more related to the fact that: why does it seem to be the case that that data could be extracted from English GP records when GP records exist in the SAIL Databank in Wales?
LADY HALLETT: But was the introduction to that point that England had better ethnicity data?
MS SPECTOR: Yes, my Lady, yes.
LADY HALLETT: I don't think you've answered why did England have better ethnicity data than Wales, as far as I can tell. But maybe you have and I've misunderstood.
A. No, that's a fair question, and I don't know if England does have better ethnicity data than Wales. My understanding was that if you're looking at health records, for example, there are common challenges across

both health systems, and that's why linking data together is so beneficial.

MS SPECTOR: To perhaps put the question in a slightly different way, do any gaps remain in the KAS, in the SAIL datasets in relation to the ability to disaggregate health information by protected characteristics?

A. There are certainly a range of issues related to availability of data on protected characteristics and they would affect data available in SAIL but also data that exists outside of SAIL as well, and we've already noted ethnicity being one particular example.

I think that's particularly acute for Wales because Wales is a small nation with a small ethnic minority population, so if you are collecting data through surveys, for example, you have to have a very large survey in order to be able to break the data down by different ethnic minority groups. So that's a particular challenge.

There are other challenges related to disability, for example, where most data is collected under the medical model for disability. We do not, as a statistics system across Wales or the UK, have an established method for collecting data through the social model for disability, although that is something we're actively looking at at the moment.

Q. Moving on now to data on social care.

Yesterday this Inquiry heard evidence from Helena Herklots, the Older People's Commissioner for Wales, who described that initially in the first wave the data on deaths from Covid-19 did not include older people who died in care homes. Is that correct?

A. So perhaps it would be helpful to set out the two different sources of data around Covid-19 mortality. So you have the rapid surveillance data that is collected by Public Health Wales that comes through their e-form that was used to collect this information. That information predominantly focused on deaths in hospitals. My understanding is it was never designed to be full coverage of all deaths, it was about being able to rapidly identify trends in mortality. So it may have captured some deaths in care homes, but it wouldn't have captured all deaths in care homes.

The ONS data which comes from death certificates would capture all deaths and would be attributed to Covid-19 where that was mentioned on the death certificate.

Q. Are you able to assist us with a date when the Welsh Government was in receipt of reliable and comprehensive data of all people who died in care homes due to suspected or confirmed Covid-19?

A. That would have come from the ONS data, which would cover all care homes. There was also an additional source from Care Inspectorate Wales, so Care Inspectorate Wales is required to be notified of a death of a care home resident and the Welsh Government had access to that information from relatively early on in the pandemic. I know we began publishing it from early May but we would have had access to it internally earlier than that.

Q. Now, the ONS has published a number of blogs and lessons learned reports during the pandemic, and one of these is called "Glimmers of light for adult social care statistics", dated 8 July 2021, which you can see before you on the screen. That blog summarised the concerns that the ONS had been raising relating to adult social care in Wales and amongst all UK nations, it's not unique to Wales.

Its findings, as you can see on the screen before you, were that:

"[1] Adult social care has not been measured or managed as closely as healthcare, [with] a lack of funding [leading] to under investment in resourcing in data and analysis.

"[2] There is an unknown volume and value of privately funded provision of adult social care."

Just moving on:

"Robust, harmonised data supply to ensure comparable statistics from both public and private providers is problematic, as data collection processes are not always standardised."

And moving on:

"Data quality is variable within and across local authorities, with inconsistent interpretation of data reporting guidance by local authorities."

The post goes on to say, just in the next sentence below:

"As data issues go, as the pandemic has highlighted, there is not so much a gap as a chasm, with consequences to our understanding of social care delivery and outcomes."

Now, as I've said, those findings are not addressed uniquely to Wales, but is it fair to say that these problems persisted in Wales in March 2020?

A. Yes, I think that's a fair summary.

Q. Now, in terms of listing the changes that have been made since then, the blog proceeds to list five tangible changes being made by the UK Government on this issue for data in England, such as the monthly publication of a statistics report on adult social care in England. Just regarding actions being taken in Wales, the post

simply says "the Welsh Government remains committed to improving the data it captures on social care".

So can I ask you: what is the Welsh Government, assisted by KAS, doing on this issue?

A. So I think there's probably two different strands to this: there's things specifically related to the pandemic and then there's social care data more generally.

So during the pandemic I've already mentioned the data that was available from Care Inspectorate Wales, so that was a new source of information that we began using to learn more about the pandemic and how it affected care homes.

We also stood up a weekly, what we referred to as a checkpoint survey of local authority social services. Social care and social services generally doesn't have the same kind of timeliness of information that the health service has, and so this weekly survey was a way of understanding the demand and local social services' ability to respond to that demand during the pandemic.

Outside of the pandemic, more broadly, we have been putting a lot of effort in recently into improving data around adult social care and adult social services more broadly. So this year, for example, we will start collecting what we're calling an adult census of people

who use social care services, so that will give us much more granular information about people who use local authority social care services.

Q. Moving on now to occupation data.

Another group at higher risk of contracting Covid-19 were healthcare workers and social care workers.

With that in mind, please, can we look at document INQ000395589.

If we could please go to the bottom of page 4 and the top of page 5, this is an email thread between members of Public Health Wales about data reporting in Wales, and we can see that Dr Frank Atherton was copied in to those emails.

The first email in the thread was sent on 14 April 2020. If we look at that first sentence that's highlighted in yellow:

"They [meaning the ONS] are looking at developing a new process for capturing deaths in HCWs [healthcare workers] and adult SCWs [social care workers] -- this was discussed with the DAs at the weekend and is under review."

Then if we scroll up to the thread on page 3 and an email sent on 15 April, again from a member of Public Health Wales, and if we look at the second sentence highlighted in yellow:

"DHSC/PHE are asking the DAs to confirm what they are doing about information about staff number deaths -- would like an update on this urgently."

In the next email thread, at the bottom of page 2, an email from a further member of Public Health Wales reads:

"In meeting with Minister [meaning Vaughan Gething] where he agreed we hold our line that there is no reporting on NHS staff deaths, in Wales, by [Public Health Wales]."

Then the final email in that thread on page 1 says:

"We do need a handle on HCW deaths ourselves."

In March and April of 2020, do you know whether KAS was asked to assist Public Health Wales in identifying healthcare worker or social care worker deaths?

A. I don't know if we were asked in that specific period, it wasn't something I was involved in, but I do know that Public Health Wales did add a flag around healthcare worker deaths and social care worker deaths in their e-form that they use for rapid surveillance and mortality purposes as a way of helping to collect this information.

Q. Do you know when that took place?

A. I think that was added in early May, from memory.

I do know also that colleagues in Knowledge and

Analytical Services asked the Office for National Statistics as well to provide information from their mortality data that would tell us the numbers of healthcare workers and social care workers in Wales who had died from Covid-19.

LADY HALLETT: Do you know what the argument was in relation to no reporting?

A. I don't know. My suspicion might be that it was because there would perhaps be very small numbers and you might not want to disclose some information about someone that wasn't public, but that's just a guess.

LADY HALLETT: Thank you.

MS SPECTOR: In your opinion, was that an important dataset to try and receive?

A. Yes, there was certainly a lot of interest in understanding the potential risk that healthcare workers and social care workers were experiencing and having reliable statistics on that was an important thing to be able to do. The differentiation, I should probably make, the ONS data doesn't necessarily tell you about in-service deaths from Covid-19, so it would tell you whether someone had died from Covid-19 but not necessarily whether it was something that had been acquired in the line of work, for example.

Q. Moving on now, we'll look at some of the charts that you

provided with your witness statement concerning Covid-19 infections and hospital data in Wales.

So first please can we have figure 1(a) in your witness statement INQ000399709.

This illustrates the weekly hospital admissions for Covid-19 and non-Covid-19 conditions in Wales from March 2020 to June 2022.

Are you able to explain to us what this chart shows?

A. Yes, so this is the weekly hospital admissions for Covid. It includes both suspected and confirmed cases. And you can see that that blue line at the bottom shows the Covid-19 cases with some distinct peaks in the early phase of the pandemic in sort of March/April 2020, and then other peaks towards the end of 2020, early 2021.

Q. If we could now, please, have on screen INQ000412041 and the slide on page 2.

This chart shows the number of beds available compared to the number of patients across hospitals in Wales, and we can see here that the pale orange line represents confirmed and suspected Covid patients; the orange line, designated Covid beds; the pale blue line, total patients in hospital; and then that dark blue line, all general and acute beds.

For clarity, am I right in saying that that red line for designated Covid-19 beds does not represent maximum

capacity for Covid-19 patients in hospital because designated -- beds that were not designated for Covid-19 could still be used for Covid-19 patients?

A. Yes, that's correct. Generally we would look at occupancy across the hospital as a whole rather than designated Covid-19 beds per se.

Q. With that caveat in mind, are you able to talk us through what this chart shows?

A. Yes, so if we're looking specifically at the Covid-19 series at the bottom there, it follows a similar trajectory to the admissions data in the previous slide. It shows that there were peaks in the spring of 2020 and again in late 2020 and early 2021, and that at times the number of confirmed and suspected Covid patients was close to or slightly over, in some cases, the designated Covid beds, although noting that there would still be other capacity available.

Q. Can we also see that the availability of those Covid-19 designated beds was more limited in the second wave than in the first wave at times?

A. Yes.

Q. We're going to hear about decisions that were made in Wales in waves 1 and 2 based on concerns about hospital capacity later in the next two weeks. This chart suggests that capacity was never near to being

meaningfully exceeded in Welsh hospitals. However, the figures that we see are combining all hospitals and health boards. Are you able to assist us with whether there were certain hospitals or health boards that were more consistently near or at capacity during the Covid-19 pandemic?

A. I'm afraid that's not a level of detail that I can help you with.

Q. If we now look at the chart on page 5, of INQ000412041, this chart shows invasive ventilated beds in Wales, April 2020 to June 2022. Just, again, are you able to talk us through what we can see in this chart?

A. Yes, so there are two series here. The blue line represents the number of invasive ventilated beds that were available, these would typically be in a critical care environment but not always in a critical care environment. And then the yellow or orange line is the beds occupied, and that is for both Covid-19 and non-Covid-19 patients.

And similar to some of the previous series you can see some distinct peaks in the early and second phase of the pandemic.

If we look at beds available, there were a larger number of beds available that offered invasive ventilation earlier in the pandemic and then that drops

after the first phase.

Q. I'm grateful.

Finally I want to look at some charts concerning Covid-19 and discharges from hospitals into care homes in Wales during the pandemic.

Now, the ONS has published figures that there were 13,630 deaths in care homes overall in Wales during the Covid-19 pandemic. Just over 30% of those deaths were registered during the first wave, and 40% or so of those were registered during the second wave. Is that information correct?

A. I don't have the figures to hand, but that sounds correct.

Q. We've discussed already a reason why those numbers might have been slightly under-reported in care homes in the first wave. Is it likely that official figures of deaths caused by Covid-19 in care homes in the first wave might be even lower still because there may have been undiagnosed Covid cases due to less testing and less clinical experience of staff in the early days of the first wave?

A. That is potentially possible and I think that would be the same case for deaths outside of care homes as well, and that's why sometimes it's helpful to look at excess deaths overall rather than just Covid or non-Covid

deaths.
Q. Please can we now have on screen INQ000271757.
Now, am I right in saying that this is research that KAS conducted into discharges from hospitals to care homes between March and May of 2020?
A. Yes, that's correct.
Q. We can see from the top of paragraph 2, page 1, KAS analysed 1,729 discharges from hospitals to care home settings, analysing how many patients were tested prior to discharge and how many of those patients subsequently passed away.
That number 1,729, can I ask, was that all discharges from hospitals to care homes in Wales, or was it a sample size that had been taken by KAS?
A. This analysis was started before I was Chief Statistician so I wasn't involved at that time, but my understanding is that should be all the discharges that were able to be identified at that point.
Q. What this study did is it counted those who had themselves been discharged from hospitals into care homes and died rather than those who might have been infected from someone being discharged with Covid-19 into a care home and who then subsequently died; is that right?

A. Sorry, could you repeat that?
Q. I can. The study counted people who had been discharged from hospital with or without a test and who had subsequently died from Covid-19 rather than people who might have been infected by those people who had been discharged without a test?
A. Yes, that's right, it didn't attempt to look at that issue around whether discharging from a hospital to a care home was related to an outbreak of Covid-19, it was simply looking to describe the number of discharges that happened and the testing activity associated with that. There was other work that had tried to look at that more complex question.
Q. If we look at the final paragraph on page 1:
"Of the 81 discharged patients who by the point of data extraction on 30 June 2020 had died of COVID-19 related causes, 62 did not receive a test in hospital prior to discharge ..."
If we then look at page 7 in the chart in the middle of that page, which is chart 3, that chart shows the proportion of discharges to care home settings where a test was taken in hospital prior to discharge and those that did not have the test, and we can see that dark blue there is "No test taken".
If we focus on the week commencing 27 April, and

that bar, we know that the Welsh Government announced on 24 April that mass testing would commence for all patients being discharged to care homes, which was followed by new guidance on hospital discharges on 29 April. But we can see in that bar for 27 April that the number of patients discharged without a test continued, given that we can see some navy blue space at the bottom of it, and we can see that that continued to the end of May; is that right?
A. That is what the chart shows. I guess there could be some occasions when it might have been a data issue, that we couldn't necessarily link a discharge record to a testing record, that could be a recording and reporting issue, but I couldn't say that with certainty, but it does show within the data that there were some discharges that did not have a test record associated with them after that point.
Q. If we then go to table 3 on page 8, that slightly breaks down the numbers of discharges that we're talking about in the period that we're looking at. We can see that for certain health boards the figure of discharges after the change of guidance was as high as 50% in April and 29% in May, so after the policy change; is that right?
A. That is right, but it's worth noting that there are some very small numbers involved there. So the Hywel Dda

example in April, for example, is 1, which leaves a percentage of 50%, so it's useful to look at the numbers as well as the percentages.
Q. If we look at the numbers for Aneurin Bevan for May, that gives a slightly higher -- not much, but a slightly higher -- number of discharges, and we get the 17% there.
In terms of the conclusions that could be drawn from that table, what is it that KAS concluded, looking at those results, about the discharges that were continuing despite the change in guidance?
A. I mean, I think our conclusion was that there were still some records where there appeared to be a discharge from hospital to care home without a test record after the point at which the guidance changed. That could be because it wasn't possible to link a record, that could have been a data reporting issue, or it could have been genuinely that no test was undertaken.
Q. Who did KAS send the results of this study to?
A. So it wasn't something I was directly involved in, but I believe that they were shared with senior officials in the Welsh Government working in health and social care in around late summer 2020.
Q. Finally on this topic, the Vivaldi care home study was conducted by the ONS in the UK to measure the impact of

Covid-19 in care homes in May to June of 2020, and am I right in saying that that study concluded that care homes using bank or agency nurses most days were more likely to have more cases of Covid-19, and care homes in which staff received sick pay were less likely to have cases of Covid-19 in residence?

A. I believe that's what the study found, yes. It's a study that just covered England, however.

Q. You pre-empted my next question. Is any similar study being undertaken in Wales or has been undertaken in Wales?

A. So the report that you referred to with the bar charts in it does refer to a particular piece of research by Public Health Wales where they had looked at the risk factors associated with outbreaks in care homes, and I think they had found -- if you'll excuse me reading it so I don't get it wrong --

Q. Please.

A. -- but their conclusion was that they found that large care homes were at considerably greater risk of outbreaks throughout the pandemic and the exposure to discharge from hospital was not associated with a significant increase in risk after you take into account the care home size.

Q. My final topic is about data sharing, firstly between

KAS and the Welsh Government and the UK Government.

In terms of the speed of data sharing, Glyn Jones in his statement describes how for some areas the flow of data was generally slow or inhibited from the UK Government's end to the devolved administrations, and he particularly cites the Department for Work and Pensions. Do you agree with what he says about that?

A. Yes, I do agree with that.

Q. Are there any other examples of areas that were particularly affected by delayed sharing speeds?

A. I think the Department for Work and Pensions' data sharing is probably the most noteworthy one. There were examples of very good data sharing; the Department for Transport, for example, was incredibly helpful in sharing data around mobility and trips that people were taking. Generally data sharing was quite positive, so those exceptions were few and far between. One other that's worth noting perhaps is that we have been looking to acquire the data from the Covid-19 Infection Survey for SAIL, which is something we've not been able to do yet.

Q. In terms of data sharing and conformity of datasets, we know that each of four nations had their own datasets and means of measuring Covid-19 cases and deaths. Especially at the onset of the pandemic, is it correct

that definitions across the UK were inconsistent in their recording of deaths, for example, how data on Covid-related admissions and hospitalisations were measured for each nation, and the fact that Wales included suspected cases for some measures where other nations didn't?

A. On hospitalisations, yes, that's correct. Broadly we were able to work together to understand the differences, but at the outset there, there were certainly differences there.

Q. Were those differences that were worked out quite rapidly in the course of the pandemic?

A. So I think perhaps those differences carried on throughout the course of the pandemic but we were able to understand where we could and couldn't compare data better, if that makes sense.

Q. Are any steps in motion to attempt to harmonise that kind of data collection for future --

A. So I think we probably learned quite a lot from that experience. I think each nation in an attempt to be helpful moved quite quickly to start collecting its own data, but that then potentially meant that we had some small differences in the definitions we used across the UK. That's something we've learnt from in, for example, the response to the Ukraine -- the invasion

of Ukraine and the data-related demands for that: we worked together across the nations to come up with a single set of statistics. So it's about learning to take a couple of days to work together to avoid those kind of issues in future.

Q. My final question is about the ONS. Professor Sir Ian Diamond earlier today was asked whether there were any changes in collaborating with KAS during the course of the pandemic and he said that there weren't any. Is that something that you agree with?

A. We certainly had very positive relationships with the Office for National Statistics. We were involved very closely in things like the development of the Covid-19 Infection Survey, they were very amenable to our requests for data and for additional analysis. However, I do think they were probably more closely embedded with the UK Government than perhaps the Welsh Government, and that potentially meant that UK Government requests were perhaps prioritised or understood more than requests from the Welsh Government.

MS SPECTOR: My Lady, those were all of my questions.

LADY HALLETT: Thank you very much.

I think, Ms Gowman, you have permission for some questions.

Questions from MS GOWMAN

MS GOWMAN: Thank you, my Lady.

Ms Howarth, I ask questions on behalf of Covid-19 Bereaved Families for Justice Cymru.

Firstly in respect of the Covid-19 analysis hub established on 23 March 2020, just briefly, you've described today that the responsibility of the hub was to bring existing information together for use within Welsh Government. In other words, it provided Covid-19 statistical analysis to inform advisers and decision-makers in the Welsh Government; is that a fair summary?

A. Yes.

Q. So an important function?

A. Yes.

Q. The former Chief Statistician, Glyn Jones, states in his witness statement that the hub started life as a team of seven people; is that correct?

A. That is correct, yes.

Q. Initially did the staff in the hub act on a voluntary basis alongside other responsibilities?

A. That is correct, although most of those other responsibilities were largely paused, which enabled them to contribute to the work of the hub.

Q. And that may answer my next question, but do you question that the limited team of seven and the fact

that staff were acting on a voluntary basis alongside other responsibilities, did that in any way impact on the hub's ability to respond to requests in the early stages of the pandemic?

A. So there were a range of other statistical and analytical staff also supporting the hub, so they weren't the only people responding to requests. So if an example would be helpful, the team that leads on economy and labour market statistics would help contribute to work around that topic related to the pandemic. But that notwithstanding, I think it was a big ask for a small team to be able to accommodate the growing number of analytical demands during that time.

Q. And certainly Glyn Jones suggests that by the summer of 2020 demand was outstripping supply; is that fair?

A. Yes.

Q. What impact do you think that that had on the hub's ability to respond to policymakers to inform decision-making?

A. So I think we did -- the key information was made available and we were able to work with policy officials, but perhaps the thing that we were less able to do was be more proactive. It was much more reactive to the kind of demands that people had for statistics during that period, rather than more closely embedding

yourself with the policy team.

Q. And in future, what lessons do you think that can be learned from that scenario?

A. I think it shows that you need suitable analytical capacity within an organisation to be able to work collaboratively with policymakers. I don't necessarily feel like there was a deficiency in the use of analysis, but I think that we potentially could have gone further in anticipating some of those demands. But also it creates a significant impact on the small number of individuals concerned in terms of their own wellbeing, and I think a large capacity can help avoid some of those challenges as well.

Q. Avoids burn-out?

A. Yes.

Q. Yes.

Secondly, we know that five new analytical posts were agreed in June 2020 for the hub, and six new posts were agreed in November 2020. What isn't clear from the evidence at the moment is whether those posts were filled. Are you able to assist?

A. They were, but it took a period of time for them to be filled.

Q. Do you agree with your colleague, Glyn Jones, that, notwithstanding these vacancies having been advertised

and indeed, as you've set out, eventually being filled, recruiting sufficient specialist resources remained a constant challenge throughout the pandemic and, secondly, that this meant that certain projects could not be adequately resourced?

A. It was a challenge to resource analytical roles. There are only a finite number of analysts within government. We benefitted from being able to bring in, for example, colleagues from arm's length bodies, we had a small number of loans from the Office for National Statistics, but it was a continual challenge to be able to fill the analytical capacity that we needed.

Q. And in terms of the second part of the question, did that mean that certain projects couldn't be adequately resourced?

A. There were -- generally I think it probably meant that we were slower to do things than we might have liked rather than they couldn't happen, but there were some examples where -- one particular noteworthy one was the Technical Advisory Cell had a dashboard, an internal dashboard, that they had brought together to interrogate some key sets of data, I would have liked that Knowledge and Analytical Services together with our digital colleagues would have been able to do that, but we didn't have sufficient capacity to be able to do that,

so that was something that was contracted out.
Q. And aside from that example that you've given, how else, if at all, did the resourcing constraints impact on policymakers during the pandemic?
A. I think broadly we were able to meet policy demands, I can't think of a specific example that impacted policymaking, but it did often mean that people had to go above and beyond and work long hours to do so.
MS GOWMAN: Thank you, Ms Howarth.
Those are my questions, thank you, my Lady.
LADY HALLETT: Thank you very much.
Mr Gardner, I gather there's a question the Children's Commissioner would like asked.
MR GARDNER: Thank you, my Lady. I wonder if I might lean forward and obtain a ...
LADY HALLETT: A lectern for one question, Mr Gardner.
MR GARDNER: My eyesight, my Lady.
LADY HALLETT: Actually it's user technology, isn't it? I hadn't thought about that.
Questions from MR GARDNER
MR GARDNER: Ms Howarth, the Inquiry has just heard from Professor Diamond. I don't need you to turn to it, but in his first statement at paragraph 166 he refers to a school infection survey and notes that that was an England-only study. Are you able to confirm if any

equivalent study was taken during Covid relating to Wales?
A. There wasn't an equivalent study in Wales, no. I recall that we had discussions with ONS about their survey to understand how it worked, determine if it might be possible to extend to Wales, but from memory I recall it was quite an expensive survey to get up and running and there wasn't necessarily the funding available to do that.
Q. So you wouldn't have been involved in risk profiling, but -- correct me if I'm wrong?
A. No.
Q. But the result of that would be that those who were making decisions about risk profiling wouldn't have had data available to them specifically about schools in Wales, then?
A. It depends what data you mean. So they wouldn't have had that specific data from the infection survey but there were other sources of data. Colleagues in Swansea University, for example, had linked together a range of data to understand transmission in schools. So there were a range of different data sources but the school infection survey run by ONS was an England-only survey.
MR GARDNER: I'm grateful. Thank you, my Lady.

LADY HALLETT: Thank you, Mr Gardner.
I think you have one further question that John's Campaign wishes you to ask. Yes, Ms Spector.
Further questions from COUNSEL TO THE INQUIRY
MS SPECTOR: Yes, I do, my Lady, thank you.
Ms Howarth, you confirmed that the rapid surveillance data did not cover all deaths, it did not capture all deaths in care homes, but that ONS would have captured all of those deaths. How did the publication of that data work?
A. Of the ONS data?
Q. Of the ONS data, yes.
A. So ONS published that data on a weekly basis, I think it was, with an approximately ten-day lag, I believe, from memory. And I think as part of that they would regularly break down data by place of death.
I think it might also be useful to add that we shared data from the Welsh Government with ONS, the Care Inspectorate Wales data I mentioned, which helped them to produce their analysis around deaths of care home residents as well.
Q. Sticking with the ONS data, would earlier figures that may not have included care home deaths have been updated retrospectively when the complete ONS data was received?
A. So I'm not an expert in ONS's mortality data but my

understanding is it should cover all deaths that have a death certificate. So that would be regardless of where the death occurred, so they should all be in there, is my understanding.
Q. Forgive me, I think the question simply is about whether earlier figures would ever be corrected to account for later figures?
A. I'm not clear on how the ONS mortality data works, but I imagine that there would be updates for any late returns, for example, or delays in registration that were received.
MS SPECTOR: I'm grateful, my Lady.
LADY HALLETT: Thank you very much indeed, Ms Spector.
Thank you very much indeed for your help, I'm very grateful to you.
THE WITNESS: Thank you.
LADY HALLETT: We'll break now, I think, we might as well between witnesses, and I shall return at 3.15.
(3.00 pm)
(A short break)
(3.15 pm)
MR POOLE: I call Dr Robert Hoyle, please.
DR ROBERT HOYLE (affirmed)
Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2B
MR POOLE: Dr Hoyle, could you start, please, by giving us

your full name.
A. Robert Thomas Hoyle.
Q. Thank you very much for attending today and giving your evidence.
Can you please remember to keep your voice up so we can hear you, but also so your evidence can be recorded.
If at any stage you need a break, do say, and if I ask you anything that you don't understand, please ask me to rephrase it.
Your witness statement for this module of the Inquiry is at INQ000347980 and we see the first page there. We don't need to go to it but, page 26, you signed that statement on 30 October last year. Can you confirm that the contents of that statement are true to the best of your knowledge and belief?
A. It is.
Q. I'm grateful.
Dr Hoyle, are you at present the head of science for the Welsh Government Office for Science?
A. I am.
Q. That's a role you've held since May 2019?
A. Yes.
Q. Before that you worked in the Welsh Government's Science division to support the then Scientific Adviser for Wales, who was Professor John Harries, and you managed

the Engineering Centre for Manufacturing and Materials. And prior to 2010 you worked in the energy and manufacturing sector; is all of that correct?
A. Yes.
Q. Is it also correct that you have served all four officially appointed Chief Scientific Advisers for Wales?
A. Yes.
Q. Can you please provide a very brief overview of the roles and responsibilities of the head of science for the Welsh Government?
A. My main role and principal role is to support the Chief Scientific Adviser for Wales, of which we've had four that I've served, and that is principally about providing scientific advice and evidence to government, although we do do other things. One other piece of work that we are doing at the moment is related to medical radioisotopes and that is quite a technical issue, related to the supply of medical radioisotopes to the NHS and other health services.
So -- but that, again, is about collecting evidence and data and information to support policy development or strategy development.
Q. Just help us, where does your office sit within the structure of the Welsh Government?

A. So the Chief Scientific Adviser is a public appointment, and normally reports to the First Minister, although for pay and rations, if I can use that phrase, we sit within ETC, which is Economy, Treasury and Constitution, at the moment, but we sit within the Economy portfolio of the minister Vaughan Gething.
Q. As a very broad overview of your role during the pandemic and the various advisory groups that you served, I think I'm right in saying that you were a member of the Technical Advisory Group from 13 April 2020, that's what's known as TAG?
A. Yes.
Q. And you were also a member of the Technical Advisory Cell, TAC, from mid-April 2020?
A. Yes.
Q. You were also a member of the international group and in fact chair of the international intelligence subgroup from September 2020 to the end of 2022; is that right?
A. That's right.
Q. And that's the international intelligence group perhaps -- I think known, shorthand, as IntTel; is that right?
A. Yes.
Q. One of the issues in this Inquiry is the degree to which the Welsh Government understood and engaged with

pandemic strategies of other countries as a potential model or as a guide for their own pandemic response.
So as the chair of IntTel, you were involved in the surveillance and collection of data from other countries' pandemic responses; is that right?
A. I was, yes.
Q. Can you briefly explain to the Inquiry the purpose of IntTel?
A. The main purpose, as set up, was to observe what was happening elsewhere in the world and to see whether lessons could be learnt from elsewhere in the world that might be applicable to Wales.
Q. Am I right IntTel was set up in September 2020?
A. Yes.
Q. How did IntTel come to be established at that time during the pandemic?
A. Prior to that and prior from -- right from the start of the work, we started in March, we started to look at within the Welsh Government Office for Science what was happening elsewhere within the world, in different countries, to see how the pandemic was developing in different countries, and then over a period of time it was felt, because of things that were happening within TAG, that we should formalise it more by creating an international subgroup of TAG. So we went from being

a sort of localised activity within the Welsh Government Office for Science to a broader activity which included a range of experts from external to the Welsh Government.

Q. So the surveillance and collection of data from other countries was going on within TAG from March 2020, but it became formalised and put into a specific subgroup in September 2020; is that accurate?

A. Not quite accurate, it was -- the international intelligence work that was going on was conducted by the Welsh Government Office for Science, principally myself and members of my team, and then we reported -- I reported to TAG on a regular basis the international situational report, as it's often or was often known, so I reported not every week or not every meeting but on a frequent basis about what was happening elsewhere, and then when other subgroups were being formalised and sort of growing out of activities and the need to pursue discrete lines of research or evidence gathering, then I formalised this into an international group, what became IntTel, in September of 2020.

Q. I understand. What kind of requests were made about international comparisons, what kind of evidence or information was sought from IntTel?

A. From TAG or from elsewhere?

Q. From TAG.

A. Right. Initially we had requests that came through TAG from ministers or directly from TAG, from TAG meetings to investigate issues that were relevant at the time. One of the issues that we looked at in considerable depth was the difference between the pandemic in Latin America and how that was progressing to how it was progressing in Western Europe, in Northern hemisphere.

And what we're looking at there, to see whether there was a difference between northern hemisphere and southern hemisphere developments of the pandemic. Of course this comes down to seasonality and whether the pandemic had a strong seasonal component to it or not. So we looked at the different hemispheres at the same time because they have different seasons. If it's summer in the northern hemisphere it might be winter in the southern hemisphere. So that was one piece of work that we looked at.

Another piece of work that we did was on the R0 value and we submitted a paper to the First Minister on that. But it varied, the requests that were made of us were varied. But that didn't stop us exploring our own issues where no requests were forthcoming because we were observing about what was happening at the time and we picked up on things that we thought would be

interesting to investigate.

Q. I think you say in your witness statement that many requests were verbal and knee-jerk or had a panic flavour about them. Is that right? It was more reactive than formal considered commissions?

A. Certainly in the early days, yes. Things were happening so quickly that a sort of more formal commissioning system didn't materialise. The requests were typically in meetings, "Please could you have a look at whatever", in TAG meetings, and we would go off and have a look at whatever and report back.

Over time, that became less panic-stricken, shall we say, or -- panic-stricken is not quite the right word, but fast-moving.

Q. You've referred to some countries that you looked at data from. Did you consider data and intelligence from South East Asian countries, so, for example, Taiwan, Vietnam, South Korea, who already had extensive experience in effective mitigations from viruses such as SARS?

A. Yes, we did.

Q. In the course of evidence tomorrow, the Inquiry is going to hear from Dr Roland Salmon who was an advocate for a Welsh approach to the Covid-19 pandemic that more closely resembled Sweden's response to the pandemic. Is

that a matter that you considered in IntTel?

A. At great depth, yes.

Q. Could you just provide the Inquiry with a brief overview of the course chartered by Sweden in the course of the pandemic and how this differed from the Welsh approach.

A. Sweden didn't insist on a harsh lockdown in the manner that many other Western European countries did, or indeed countries across the world did. They had a much more laid-back approach to it, and in the early days it looked like they were handling the pandemic more effectively. Which raised the question about the effectiveness of lockdowns. However, when we dug into it in a bit more detail, it became obvious, and one clear point became obvious to us, the number of single occupancy households in Sweden is much higher, that's one person per household, in Sweden than many other more populated and more densely populated countries. So they had a degree of built-in self-isolation that many other countries didn't have and don't have, which meant that you can't make direct comparisons between densely populated countries and less densely populated countries like Sweden.

Q. I think you may be close to answering this question already, but what are your views about the viability, then, of Wales and the UK in general mirroring Sweden's

strategy?
A. We have much greater densities of population and much higher population in our major cities than many parts of Sweden, so I don't think you can draw the same conclusions or lessons from Sweden and expect them to work in the UK. The conditions are different.
Q. Did you receive proper feedback on the work that IntTel did? Did you feel as though you received sufficient consideration?
A. From TAG?
Q. Yes.
A. It was variable. On several pieces of work we received no feedback, on other pieces of work we did receive feedback, but it was somewhat ad hoc. But there again that was partly a reflection of the rapid changing nature of what we were doing and looking at. Quite a few of the things that we looked at and were requested to look at, things had moved on by the time that we'd looked at them, because inevitably it takes time to look at some of these things. But overall there were times when I wished there could have been more feedback.
Q. And who would you say is responsible for the lack of feedback?
A. That would come down to the chair and the deputy chair.
Q. Do you feel as though TAG and TAC and Welsh ministers

took IntTel sufficiently seriously as an information resource during the pandemic?
A. Sufficiently -- perhaps not sufficiently seriously. I think a lot of the focus, and rightly so, of TAG and TAC was what was happening in Wales, and that meant that they didn't have necessarily the bandwidth to cover, you know, a much broader perspective as to what was happening in the rest of the world.

They did take great notice when things like the new variants started to appear, like the Delta in India or the Brazilian variant or the Omicron variant, and so on. But there again that was transitory because things were happening so quickly, and the threat to the UK was obvious, and so they took much more interest in what we were doing.
Q. Do you view this -- if I can call it sort of insularity as a shortcoming, being too Welsh-focused?
A. I wouldn't say it was a shortcoming, no. I think it was an insufficiency but not a shortcoming.
Q. Now, during the course of the pandemic, did you attend most TAG/TAC meetings?
A. Yes, apart from on the occasion when I was actually on holiday, I made a point of attending every single one of them.
Q. And how or by whom were the discussions and advice

formulated by TAG communicated onward to the Welsh Government and ultimately the Welsh ministers?
A. As I understood it, the information that we provided was assimilated and assessed by the TAG/TAC leadership, the chair and co-chair, and then passed on as appropriate to the Chief Medical Officer and other Welsh Government people, and ultimately to ministers.
Q. How transparent was that communication of advice to Welsh ministers through either the CMO or the Chief Scientific Adviser for Health?
A. It wasn't particularly transparent, but that's not to say that it wasn't happening. It was just that we didn't witness it. I didn't witness it to any great extent.
Q. Did you ever see any kind of record of what advice had been given verbally from, say, Dr Atherton or Dr Orford to Welsh ministers?
A. No.
Q. If there had been dissent or debate within TAG, are you aware of whether that debate was accurately conveyed to the Welsh Government, Welsh ministers?
A. I ... I can't answer that, I'm afraid, I don't know.
Q. Perhaps put another way, is TAG advice formulated as a consensus view or as an overview of a debate on any one topic?

A. Most of it was consensus view, yes.
Q. In that sense similar to SAGE?
A. Yes.
Q. Do you consider in your experiences of TAG that there was sufficient challenge on TAG and also TAC, was there sufficient challenge on issues or was there a culture where people didn't feel able to speak up and challenge during a discussion or debate?
A. There was plenty of -- can I use the phrase -- soft challenge, but really hard challenge I didn't feel there was sufficient.
Q. Were there, though, meaningful debates within TAG and TAC that actually affected the advice or the outcome of the advice that was then passed on to the Welsh Government?
A. Well, there were certainly debates, there were certainly debates, but it was done in a very collegiate manner. But I can remember on occasion there was serious challenge, really off the wall challenge, and I felt that at the time that wasn't particularly well received. Soft challenge was quite acceptable, and there was a lot of encouragement for soft challenge, but not really hard challenge of the type that -- you know, questioning whether lockdown at all was a good idea.
Q. So, I mean, would it be fair to say that TAG was used by

Welsh ministers as a place where information or advice could effectively be rubber stamped?
A. No. No, I don't think that was the case.
Q. Were you and your colleagues on TAC -- TAG informed about how your advice impacted policy, did you see the advice feeding into policy decisions by Welsh ministers, or do you think you should have been appraised of that?
A. I think, yes, we -- for instance, the firebreak lockdown, we debated that long and hard within TAG, and that did feed through to a lockdown, a firebreak lockdown, in the autumn time of 2020, I think it was. So we'd debated it and I think that did feed through into the discussions and decision-making by ministers.
Q. Dr Hoyle, I will come a bit later on to look at some of the TAG advice around the firebreak lockdown.
Just before moving away from this topic, Welsh Government in general, as head of science you suggest in your witness statement that the value of science was not understood by decision-makers in Wales and you say is fragmented across different portfolios in the Welsh Government. What impact do you think this had on the Welsh Government's response to the pandemic and what lessons should be learnt from that?
A. That is a general statement rather than a specific statement related to the scientific advice being

provided by -- for Covid. I think ministers did seek scientific advice on Covid-related matters, but my comment there was a more general comment about scientific advice generally informing policy and strategy within Welsh Government.
Q. I understand.
If we can now talk about the initial stages of the pandemic, so the particularly January, February and March period. You say in your witness statement that you were reporting to your son in the middle of February that Covid-19, in your words, "will change the world", and you say by that stage, so again this is mid-February, it was obvious to you that the genie was out of the bottle and there would have to be a major intervention to prevent a dire outcome.
Why was it obvious to you in mid-February that a major intervention would be required?
A. The rate at which it was spreading across the world and the number of countries in which it had started to appear and in certain countries, like Italy, the impact that it was having on some of the communities in, I think it was northern Italy. Not to mention, of course, the impact that it had on communities in China. So to me it was obvious from the rate at which it was spreading within communities, but the rate at

which it had spread across the world, it was more or less unstoppable at that point and that, you know, drastic action would be necessary.
Q. Was this a commonly held view in the Chief Scientific Adviser, so that's Professor Halligan's office at that time, mid-February?
A. Not really, no.
Q. Do you think that the Welsh Government appreciated the potential scale of the pandemic at that stage in mid-February?
A. I think it was dawning on certain people, yes, and the Chief Scientific Adviser for Health, it was dawning on him, the scale of the challenge here -- or the scale of the threat.
Q. When did you start discussing the pandemic within the Chief Scientific Adviser's office?
A. The week before the lockdown, approximately, I think I gave my date in my statement, and I made a note in my diary of, you know, "Started work on Covid", although I'd of course started work long before then, I'd been monitoring it since December 2019.
Q. So you've identified in mid-February that a major intervention would be needed to prevent a dire outcome and yet in the Chief Scientific Adviser's office Covid was not discussed until the week before lockdown, so

that would be sort of the week before 23 March.
A. The Chief Scientific Adviser for Wales, we did -- I did raise it with him on occasion, but it was a case of: that's someone else's problem. That was the response that we had.
Q. So that was Professor Halligan's response to you informing him of your views?
A. He didn't state that, but that was the implication of his actions or lack of actions, that it wasn't for him, and that it would be a Health issue.
Q. Do you consider that action was required by the chief science adviser?
A. For Health or for Wales?
Q. For Wales.
A. Wales.
Q. So we're talking about Professor Halligan, your office.
A. I went out of my way to encourage him to engage in this and to do things. He eventually took that advice, but not until very late in the day. I think he could and should have done more.
Q. What is it that the CSA and the CSA's office could and should have been doing in terms of preparedness and response in this period mid-February to mid-March 2020?
A. I think engaging much more closely with the Chief Scientific Adviser for Health, the Chief Medical

Officer, ministers and others, and offering to engage and offering to undertake whatever was requested of them, so offering work.

Q. Now, was the work that you've just identified as what should have been doing, was that work picked up by others, so for example the Chief Scientific Officer for Health, Dr Orford?

A. It was -- after the lockdown, he -- that's when we got engaged in TAG and TAC, so the -- I don't know how it happened, but I think the request must have come through and the expectation that at least we should engage in TAC and TAG if nothing else.

Q. Did you find it a difficulty at the time reporting to Professor Halligan on the one hand as the Chief Scientist and Dr Orford in your capacity as a member of TAG and TAC?

A. There was no difficulty, no.

Q. Now, in your opinion, was a national lockdown necessary in March 2020?

A. Yes.

Q. Do you think greater regard should have been given to the experience of countries that were several weeks ahead of the curve, so you I think mentioned Italy earlier, in the lead-up to that decision to enter a national lockdown?

A. Well, I think at UK Government level they were looking at what was happening in other countries and the necessity for regional or total national lockdown. Within Welsh Government, I wasn't privy to any discussions regarding lockdown, I wasn't aware that a decision had been made by ministers and an approach to UK Government to seek a national lockdown, I wasn't aware of that until January this year. My view at the time was that the leadership and decision-making came from the UK Government rather than Welsh Government, although I've since learnt that the Welsh First Minister, the Scottish First Minister and the Northern Ireland minister approached UK Government Prime Minister the day before the national lockdown was announced. That's how I understand it happened. But I didn't learn that until, as I say, January this year. It wasn't visible at the time.

Q. But in terms of what you knew from your own experiences at the time and in the position you were in the CSA's office, and also by the end of February TAC had been established, your impression was that this was -- there was no discussion of a national lockdown, this was something being led by UK Government?

A. That was my impression at the time, yes.

LADY HALLETT: I'm sorry to interrupt. You said that

lockdown in March 2020 was necessary. Is that because you believe it was inevitable, because of the spread of the virus, or had it become inevitable because not enough had been done early enough?

A. It was inevitable because of the spread of the virus.

LADY HALLETT: So you think, even if other things had been done earlier, we couldn't have stopped the lockdown? I mean, supposing --

A. Sorry --

LADY HALLETT: -- better prepared, for example, supposing people had acted more quickly?

A. I think by the -- I think by the time that the discussions were being had, it was probably too late to avoid a lockdown.

LADY HALLETT: Well, that's really what I'm asking. Had more been done earlier -- we'll never know.

A. We'll never know. But looking about what happened subsequently, I think by the time that January had come along it was already too late to avoid a lockdown.

LADY HALLETT: Fine. Thank you.

MR POOLE: At the time, did you think lockdown should have come sooner?

A. Yes.

Q. How much sooner?

A. In my statement I say possibly up to two weeks earlier.

I think five to seven days earlier would have been appropriate.

And I think there's a subtle timing issue here. We value our freedoms as a democratic country, and ability to move around and all the rest of it, and so it needed to get to a certain stage before widespread lockdown would be acceptable to the local -- to the national population. So it's a timing issue.

I think we could have gone probably five to seven days earlier than we did, but it needed to become prominent enough in the population's mind and the threat obvious enough for a lockdown to be acceptable. So it's a trade-off.

Q. So in terms of what you attribute the delay in implementing the first national lockdown, would it be right to say that you would say it was due to a lack of political leadership or a lack of political confidence in making a unilateral decision to lock down?

A. What do you mean by unilateral decision?

Q. Obviously we're looking at the Welsh Government --

A. I think it would have been untenable for the Welsh Government to make a unilateral lockdown ahead of a UK national lockdown, and I think ministers realised that. Because we are such a small part of the UK in population terms, I think the challenge -- there would have been

huge challenges in getting the population to accept it. And not only that, the political ramifications and accusations, as we've seen with many other things not related to this. So I think it was a national lockdown or nothing.

Q. Did TAG have involvement in the decision to lock down, was TAG commissioned to advise on the national lockdown?

A. I -- I wasn't part of TAG at that time, so I can't comment.

Q. In your view, if the lockdown had been implemented earlier, what effect would this have had on the first wave case progression and fatalities?

A. It would have smoothed the peak, and it would have prevented as many people being infected -- and fatalities, it would have reduced the number of fatalities in the first wave.

Q. What about across the extent of the pandemic?

A. I'm not convinced it would have made that much difference over the whole lifetime of the pandemic, until the point at which the whole population was effectively immunised either through infection or immunised through vaccination.

LADY HALLETT: Do you mean by that that, even if you had managed to flatten the peak -- or whatever the different analogies are that people use -- in the first wave and

therefore reduced the number of infections and deaths, you were always going to get the second wave and therefore overall the number of infections and death would have stayed the same; is that what you're saying?

A. Yes.

LADY HALLETT: Thank you.

MR POOLE: Moving beyond the lockdown into perhaps the summer of 2020, did you think that TAG/TAC had a clear objective following the lockdown of what Welsh ministers were trying to achieve with their NPIs strategy? So, for example, minimise fatalities, expedite a way out of lockdown, protect vulnerable groups, and so on and so forth.

A. The -- I asked the question on my first meeting about what the strategy was, and essentially it was to reduce harm or harms, and I was never convinced that it was any clearer than that.

Q. What are your views on the effect of Eat Out to Help Out on the transmission of the virus and the caseloads in the autumn and winter of 2020?

A. In a small way it contributed to the re-emergence of the -- into a new peak, but no more so than many of the other release activities that were going on at the time through the summer of 2020, allowing people to go on holiday and that kind of thing. So I'm not -- it was

part of the cause of the spread of the next virus -- the next wave. The virus had never gone away -- and still hasn't -- so all that had been happening is we'd suppressed it, so it was -- to my mind it was inevitable that it was going to come back, which is what it did.

Q. Am I right in saying that TAG and TAC, they weren't commissioned or asked to advise on the Eat Out to Help Out scheme, to your knowledge?

A. To my knowledge, yes.

Q. You've mentioned the firebreak lockdown already. What are your views on the need for a firebreak lockdown in October 2020?

A. It was necessary to flatten the curve.

Q. Can we, please, have INQ000313251 on the screen.

These are TAG notes from 18 September 2020 which analysed the worsening picture across Europe. If we just look at the bottom of that page, please, starting:

"The most recent data has shown that in Spain incidence per 100k has raised across the country dramatically. France has also changed rapidly in the last fortnight. Indications are the UK is currently travelling down a similar path."

So just pausing there, you say:

"Indications are the UK is currently travelling down a similar path."

What did you mean of this worsening picture in mid-September 2020?

A. That a new wave was developing.

Q. Did you think that this signalled the inevitability of a further lockdown to control those growing case numbers, or were there windows for earlier or different or less stringent intervention measures in your view?

A. In my view, as I said on several occasions to the Technical Advisory Group, NPIs and harsh and rigorous application of NPIs do work to suppress the virus and the pandemic, so I think given what was happening in Spain, and you just looked at the trajectory and the rapid increase, almost an exponential rise in cases in Spain and other countries, the UK was showing very, very, very similar characteristics, so in my mind it was inevitable that some kind of intervention would be necessary, it was just a matter of when and what. But given the nature of these things, the what tends to be a lockdown or firebreak or whatever.

Q. What is your view on the purpose of a firebreak lockdown and the consequences that that might have on the overall course of the pandemic?

A. The main purpose is to stop the health services from being overwhelmed by a massive wave of infections and seriously ill people.

Q. And in respect of the Welsh firebreak, do you think that the decision to impose it when it was imposed was taken at the right time in Wales?
A. Pretty much, yes.
Q. What about the length of the firebreak? We know it was a two-week firebreak that spanned three weekends. Was that long enough, in your opinion?
A. Erm ... probably. It's -- whether it went on for, you know, a few more days you could argue about, but I think it was an appropriate length, yes.
Partly it's about mindsets and introducing a -- or reintroducing a certain mindset in the population to say that if we don't undertake certain protective measures, then this thing is going to get out of control. And so it's -- there is an expectation that government does something, and this is government doing something, which sets the mindset for the population. So it's as much a psychological thing, I think, as a real control of the virus, but certainly a lockdown will control the virus or suppress it.
Q. Now, Dr Hoyle, just changing topic, I want to talk to you briefly about discharge from hospitals into care homes.
Were you involved in the decision to discharge untested asymptomatic patients into care homes from

hospitals --
A. No.
Q. -- or was TAG involved in that decision?
A. I don't know whether TAG was involved, but I think that was probably before my time at TAG.
Q. You referred earlier in your evidence to there being a lack of hard challenge in relation to some issues that were raised with TAG and TAC. Are you able to help us there? The answer may be no, given the answer that you've just given, but in respect of this decision to discharge untested asymptomatic patients, was that subject to harder challenge within TAG or TAC?
A. I think the decision was made before I joined TAG, so I can't say.
Q. If we can please have a look at INQ00034698, this is an email that was sent 30 April. It's an email that I think in fact you sent to Dr Rob Orford and Fliss Bennee concerning, as we can see from the title, the subject, "FM's [First Minister's] comments about no value in testing in care homes", and you write:
"Dear Rob, Fliss,
"Peter Halligan is keen to understand the rationale, evidence and advice behind the First Minister's comments last night on the telly that there is no value to testing for Cov-19 in care homes. Please can you

enlighten us. Thanks."
Why did you feel the need to send that email, what did you think of the Welsh Government's approach to discharging patients from hospital into care homes at that time?
A. Well, there's two things going on here: one is discharging patients from hospital to care homes and whether they are tested or not; and then there's the ongoing issue of testing patient and care home occupants on an ongoing basis. And they're not quite the same thing. And I think this relates to testing of people in care homes, not testing prior to discharge from hospital to care homes.
So I think we need to be careful about conflating two different things here.
Q. No, obviously, there are two issues, but you here are raising with the Chief Scientific Adviser for Health, Dr Rob Orford, a point about something that's been said by the First Minister about there being no value to testing for Covid in care homes, and I just want to know: why did you feel it necessary to send this email, having heard that?
A. Okay. This is not my normal way of phrasing such emails. I made it very explicit by stating "Peter Halligan is keen to understand", not me. So it

was in response to a request from Peter Halligan that I send this request. Normally I would say a little bit less tersely than this, or frankly than this. So the way I read it now, and I do have a vague recollection of it, it was a specific request from Peter Halligan for me to send this request off to Rob and Fliss.
Q. Do you share either the concern or perhaps it's just a question as to why the First Minister made the comments that he did? Do you share Professor Halligan's concern?
A. Well, I think there's a real issue, again, coming back to the difference between discharging untested people from hospitals to care homes, and that's different from the issue of ongoing testing of care home residents.
Now, I think there isn't a huge lot of benefit in ongoing testing of care home residents so long as they are and have been well isolated and protected. There is a lot of benefit in testing people who have been discharged to care homes, so as to prevent influx of asymptomatic people but infected people that would impact other residents of the care homes.
Q. Now, in your witness statement you link discharges to care homes with the fact that Covid-19 is an airborne virus. What is the relevance of Covid-19 being an airborne virus on this question of hospital

discharges, and what consideration was given to whether Covid-19 was in fact an airborne virus at this time?

A. At the time there wasn't -- there was a lot of debate about whether it was actually an airborne virus or whether it was passed by touching or fomites, I think the phrase is used, you know, objects. My view at the time that it was pretty obvious that it was an airborne -- mainly airborne transmissible virus. The impact that that would have would be on control of asymptomatic but infected people within care homes, and the threat that uncontrolled discharge, the threat that that would pose to care home -- other care home residents.

Q. Those concerns that you've just expressed to us, did you raise those concerns at the time, how that might affect hospital discharges to care homes, either within TAG or within the CSA office?

A. I don't believe I did, no.

Q. Do you think you ought to have done at the time?

A. Yes. And to follow up on this, we did look at testing and regime testing across different European countries, in care homes and other healthcare settings, and we did prepare a paper on that, which is not part of my evidence but we did, and I have it with me at the moment.

Q. Dr Hoyle, just again changing topic and I want to understand a bit more about the issue of behavioural non-compliance.

So as I understand it, during the pandemic in Wales there were a number of hotspot areas or areas where it appears that transmission was high and perhaps compliance was low, and so, for example, there were concerns about high case rates and lack of isolation, lack of social distancing in regions like Caerphilly and Rhondda Cynon Taf in September 2020, leading up to the firebreak. You recall those instances?

A. Mm-hm.

Q. How did TAG approach the problem of differential transmission and differential compliance with NPIs?

A. I think with great difficulty. Although there were, you know, NPI controls in place and expectations on the population to comply with the expectations, with the NPI controls, it was obvious that certain areas and certain groups were not complying. But I'm not sure that TAG really had a solution to that.

Q. Did the group of scientists who sat on TAG, do you think they fully understood or apprehended the nature and the causes of lower compliance in certain areas or amongst certain groups?

A. I think overall, no, and I think the reason for that is

that a lot of -- most of the TAG members didn't have the same life experiences that people who live in the more deprived parts of Wales or amongst some of the communities of Wales have and did have, and so couldn't relate to some of the motivations and behaviours that were being exhibited by some of these communities.

Q. Would it be fair then to characterise this as a form of groupthink within TAG?

A. Groupthink by omission, perhaps, and unconsciously. Yes, I think there was a degree of soft groupthink based on the nature of the membership of TAG. If I could explore that a little bit more, virtually all the people -- the members of TAG were either public sector, HE or other -- you know, the health sector people, all of whom could work from home on a regular basis, and so they didn't have the same lived experiences as other parts of the population. So from that respect there was a degree of unconscious bias.

Q. Could that have been remedied perhaps by commissioning more evidence in the area of behavioural science? Should there have been more data about behavioural behaviour to inform TAG's thinking in this area about non-compliance with NPIs?

A. Only limitedly. I think the best to have addressed that would be to invite other people from other walks of life

to the TAG activity. Inevitably if you commission a piece of behavioural science advice, it's done by academics and academia who are experts in sort of behavioural science, rather than lived -- experts in lived experience, and I think there's a subtle difference there.

Q. Was non-compliance attributed to behavioural fatigue?

A. Partially.

Q. And do you think rightly?

A. Inevitably, I think, rather than rightly.

Q. Now, the Inquiry has seen a 5 June 2020 TAC summary of advice document which includes a SAGE advice in it, advising on the increased risk from Covid-19 to minority ethnic groups. Now, I don't propose to display the summary of advice for the purpose of this question, but the advice suggests that this should be urgently investigated, with consideration given to how enhanced risk of poor outcomes could be managed and reduced.

The Inquiry heard yesterday from Professor Ogbonna about how Black, Asian and Minority Ethnic Covid-19 Advisory Group, how that came to be established, how it then reported later in June 2020.

In your view, were issues about the need to understand and mitigate the factors that made certain minority groups more vulnerable to poor outcomes

sufficiently considered before June 2020 when that advisory subgroup reported?
A. This is a very difficult area. My view, that there was -- people were inhibited from discussing frankly and objectively and dispassionately some of the issues involved. And I think you've just demonstrated that, if you don't mind my saying so, by saying you're not going to display the evidence in this hearing.
Q. Well, I think, in fairness, that's a limitation of time and because it's a long document --
A. Okay.
Q. -- Doctor.
But in terms of you saying people felt inhibited, I just want to explore that with you. What do you mean by people felt inhibited?
A. The whole issue about religion, ethnic minority, disadvantaged people, is, you know, LGBTQ, as it now is, quite emotive, and I think there was a reluctance amongst some to really explore some of the issues involved in any great depth.
Q. What was the effect of that reluctance, that meant it simply didn't get discussed, didn't get looked at by TAG?
A. Well, it -- some of the symptoms were looked at by TAG, but I think the attribution of cause was not necessarily

appropriate. There was a desire to try to attribute cause to populist things, if I can use that phrase.
Q. If I can ask you to keep your voice up, please, for the stenographer, thank you, Dr Hoyle.
In conversations had by TAG, what reasons were ascribed to higher transmission and higher fatality, mortality rates amongst black, Asian and minority ethnic groups?
A. Well, I think there was a tendency to try to attribute it to some of the inequalities, societal inequalities that exist. At the time there was a lot of people within the health professions who were ethnic minority, and they were being exposed because of their line of work, and there was a sort of view that maybe this is because of -- the increased infection rate amongst these people was due to their ethnicity rather than, you know, a disproportionate -- a large amount of them in a noble pursuit such as the health service.
Q. You referred earlier to an issue that you had with TAG, you said lack of lived experiences or lack of similar lived experiences. I mean, does this indicate a lack of diversity also on TAG?
A. A lack of social diversity, yes. Not necessarily ethnic or religious diversity, but a lack of social hierarchy diversity.

Q. Changing topic, to talk about face masks now briefly.
We've heard your evidence about Covid-19 being an airborne virus and the concerns that you had about that, and TAG's approach to this issue. Were you present when TAG discussed the question of face masks throughout the spring and summer of 2020, or was that before your time?
A. Well, from when I joined TAG in April 2020 I would have been present, yes.
Q. So can we just, please, have on screen INQ000221076.
This is a -- I think it's an IntTel report produced on mask wearing based on emerging evidence. It's dated, as we can see from the top, 20 January 2021. Are you able to briefly summarise the key findings of that report, Doctor?
A. Yes, the key finding of this is that face masks prevent transmission. The best advantage is it prevents transmission or helps prevent transmission from people who are infected, and there was reasonably good evidence so that if you're infected and you wear a face mask, then the chances of you transmitting it to others is reduced because the viral particles are caught in the face mask. There is less good evidence to protect people who are not infected from picking up the virus from airborne virus, although there's -- it's debatable

whether there is a small advantage.
Q. Now, we know that Wales mandated the use of face masks on 14 September 2020, which was significantly later than other European countries and later certainly than England, Scotland and Northern Ireland, and it was a significant difference between the four nations of the UK. Do you think that that was the correct approach for Wales?
A. No, I think we should have mandated it much earlier than we did.
Q. And when you say "much earlier", when do you think it --
A. At least as early as the other nations of the UK.
Q. Is the fact that Wales failed to mandate the wearing of face masks earlier and adopt perhaps one might say a more precautionary approach, is that a further example of perhaps a reluctance or reticence on the part of the Welsh Government to learn from actions of other countries? I referred earlier to a sort of insularity; is that an example of that or not, in your view?
A. I think at the time, if memory serves me correctly, the evidence wasn't very strong. This report here, of course, postdates that, this is in 2021, so I think another four months or so after we mandated it in Wales. The evidence wasn't very strong, and I think Welsh Government ministers and the Chief Medical Officer

decided on the basis of the weak evidence that it wasn't appropriate to mandate face masks in public places. I don't think that was quite the right approach. I would have gone earlier, as I said earlier.

Okay, I'm going to stop there, unless you've got more questions.

Q. Let's more to another NPI, social distancing.

A. Yeah.

Q. You explain in your witness statement that there was no science, you say, to underpin the extent of social distancing in terms of metreage; is that right?

A. Yes.

Q. Is that something you raised or is that something that was discussed within TAG at the time and, if so, what were those discussions?

A. I vaguely remember some discussion about this, but it wasn't a particularly hot topic that I recall, the whole issue about whether it was 1 metre, 1.5 metres, 2 metres, 2.5 metres or some other distance. And I quote those because those were the numbers used by different countries, the World Health Organisation advice and so on. So there was no clear advice or evidence from other countries about what was appropriate distance other than the obvious statement that further is better.

Q. Obviously there were a number of factors that are in play when making these determinations about distance, one of those being an economic consideration, and we know in the UK the UK Government in England reduced social distancing of 2 metres to 1 metre and the Welsh Government didn't follow suit and they stuck at 2 metres. Was that something that TAG was -- or can you tell us, is that something that you were involved in in TAG or that TAG advised on?

A. We did report on, in our situation reports, IntTel TAG reports, different countries and their social distancing, but again I would say that further is better, so it would be better to remain 2 metres rather than 1 metre.

Q. The Inquiry understands that you were asked to advise on school closures and looked at comparisons overseas about the first wave. Can I ask you: did other countries in Europe follow Wales' approach to close schools during October 2020 and then again during December 2020?

A. Some countries did, some countries didn't.

Q. Was any country to your knowledge, especially any European country, closing schools but at the same time keeping sort of hospitality open or vice versa?

A. I -- without doing a detailed trawl through my notes, I don't know, I can't remember.

MR POOLE: Dr Hoyle, those are all the questions I've got for you.

I don't think there are any Rule 10 questions, my Lady.

LADY HALLETT: Thank you very much indeed, Dr Hoyle. I hope we haven't kept you too long, we're very grateful for your help.

THE WITNESS: You're welcome, thank you.

(The witness withdrew)

LADY HALLETT: Right, it's 10 o'clock tomorrow. Thank you very much.

(4.15 pm)

(The hearing adjourned until 10 am on Friday, 1 March 2024)

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