Witness Statement of: Frank Atherton
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Exhibits: 55
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF SIR FRANK ATHERTON

I, SIR FRANK ATHERTON, WILL SAY AS FOLLOWS:

1. I give this statement on behalf of the Welsh Government to assist the work of the Covid-19 Inquiry. My statement will address the topic of decision making in relation to Covid-19 in Wales from 21 January 2020 to 30 May 2022 ("the specified period") with a specific focus on the imposition or non-imposition of non-pharmaceutical interventions ("NPIs") and access to and use in decision-making of medical and scientific expertise, data collection and modelling relating to the spread of the virus in Wales.

2. I have been given the responsibility of providing this statement to the Inquiry because of my role as Chief Medical Officer for Wales ("CMO(W)") during the Covid-19 pandemic. I am also the Director for Population Health, a broader role within the Welsh Government. I refer to this role below but the focus of this statement is my role as CMO(W). It was in my role as CMO(W) that I was asked to advise Ministers and Welsh Government policy officials about the public health implications of Covid-19 and the measures implemented to deal with it.

3. The relevant materials relating to the scope of this statement are substantial. By reason of the short timescale in which this statement has been prepared and the need to collate all the relevant documents, I have not had the opportunity to refresh my memory from all the documents before writing this statement. The content thus reflects my best recollection. Furthermore, the material exhibited herein is not intended to provide a complete picture, rather is material produced to illustrate key

aspects of the administration and the provision of advice to the Welsh Ministers. In light of the above, in preparing this statement I have relied on support from officials in my CMO office and have sought to provide sufficient information to assist the Inquiry in its work.

1: Role, functions and responsibilities of the CMO

4. I was appointed as CMO(W) on the 1 August 2016 and remain in that post.

5. I studied medicine at Leeds University following which I worked in a broad range of medical areas, but in particular paediatrics, and then completed my training in General Practice. After training as a General Practitioner ("GP") I joined the Voluntary Service Overseas as a District Medical Officer in Malawi between 1 August 1988 and 1 May 1990 where I formed a keen interest in public health. I went on to undertake specialist training and then to practice in public health, travelling to a wide range of different countries including former Yugoslavia, Tanzania, and Bangladesh. I worked as a Director of Public Health in Lancashire and Cumbria for a decade between 1 August 2002 and 1 May 2012 and I have served a term as President of the Association of Directors of Public Health (ADPH) between 1 August 2008 and 1 May 2012. My last job before moving to Cardiff to take up the post as CMO(W) was as deputy Chief Medical Officer for Health in Nova Scotia between 1 May 2012 and 1 August 2016.

6. The role of the CMO(W) is as a member of staff of the Welsh Government designated by the Welsh Ministers as the 'Chief Medical Officer for Wales'. Section 52 of the Government of Wales Act 2006 provides that the Welsh Ministers may appoint persons to be members of the staff of the Welsh Government and service as such is in the civil service of the State. As such the CMO(W) is bound by the Civil Service Code like any other member of the civil service in Wales. There is a difference, however, between the generally understood position of a civil servant which is often summarised as 'advise fearlessly, implement loyally' and the role of CMO. The CMO must retain a high degree of independence and separation from the concerns of the Government. Whilst this is not set out in statute or in the job description it is well established by custom and practice. I am free to provide advice without regard to government policy or direction. The best example of how this independence manifests itself is the writing of the CMO annual reports. In these reports I set out my concerns for the health of the nation and encourage the Welsh Government to respond and the people of Wales to take heed. These annual reports are not subject to vetting by special advisors or clearance by Ministers. In my experience Ministers have

understood and respected the role that I, as an independent medical advisor, serve and they translate my independent advice, along with advice from others, into decisions which affect the people of Wales. This remained the case during the pandemic.

7. The CMO post in Wales is a Director level post. I report to the Director General of the Health and Social Services Group ("HSSG") who in turn reports to the Permanent Secretary. At the start of the pandemic, Dr Andrew Goodall was Director General of the HSSG and Shan Morgan was the Permanent Secretary. In November 2021 Dr Goodall was appointed as Permanent Secretary and the Director General of HSSG post was filled by Judith Paget.

8. I consider my role as CMO(W) as threefold. Firstly, as advisor to the Welsh Ministers and the Welsh Government, bringing a public health perspective to decisions that are made, not just on the narrow subject of health but also more generally. Secondly, I am the Medical Director of the NHS so I work closely with the local health board medical directors to support the delivery of high-quality clinical service. Thirdly, I have a public health role as an advocate for better health for the people of Wales.

Advisor to the Welsh government, Welsh Ministers and Welsh Government policy officials

9. Before Covid-19 I would meet regularly with the Minister for Health and Social Services about a wide range of issues. I saw my role as providing a broad overview of the Welsh population's health; highlighting areas of concern that needed to be considered by the Government in Wales. Some examples of issues that I advised the Welsh Government on prior to Covid-19 are the effect of gambling on people's mental and physical health, childhood obesity, and the importance of research and innovation.

10. My role as CMO(W) in advising Welsh Ministers assumed a greater level of responsibility and visibility during the pandemic. This was the busiest time of my professional career and a huge challenge. This early stage of the pandemic saw a lot of meetings and workstreams being developed at tremendous pace but, from around April 2020 we began to settle in to more of a regular rhythm. The regulations that were put in place in Wales to contain Covid-19 were made under Part 2A of the Public Health (Control of Disease) Act 1984 ("the 1984 Act") and required a public health purpose. The need to consider the impact of the restrictions on public health meant that I was advising Ministers on these matters (in conjunction with colleagues such as

Dr Rob Orford, the Chief Scientific Advisor for Health) before they took decisions to implement or amend the restrictions. I set out some of the advice I gave in respect of key decisions in section 4 of the statement.

Medical Director of the NHS

11. As Medical Director of the NHS in Wales I provide professional leadership at the national level and within the Welsh Government for the medical profession, including Medical Directors of NHS organisations. I am also the Responsible Officer for the Welsh Government which is a designated body for the purposes of the General Medical Council ("GMC") revalidation, and I am the Senior Responsible Officer for the Local Health Boards ("LHBs") and NHS trusts in Wales. I am the professional lead for Doctors in Wales, and I provide clinical input to health strategy and the oversight of NHS delivery. The LHBs have responsibility for the delivery of health services; my role was to coordinate the efforts of Medical Directors through the sharing of common issues and best practice.

12. Prior to the pandemic I met monthly with the Medical Directors of the LHBs. The meeting was intended to help the Medical Directors to co-ordinate the delivery of services. Matters such as winter pressures and ideas for managing various issues would be discussed. If there had been a change in Welsh Government policy then my meeting with the Medical Directors was an opportunity to set out the policy and outline any changes in approach. In addition to these monthly meetings, it was my practice to regularly visit each of the LHBs/Trusts to meet with medical leaders and to visit services in both primary and secondary care. These visits were paused as the pandemic response unfolded.

13. During the pandemic to keep abreast of the situation within the NHS I would regularly attend the Director General's (Andrew Goodall) calls with the Chief Executives of the NHS as well as maintaining my meetings with the Medical Directors.

14. In terms of the NHS Chief Executive meetings there was a formal NHS Wales Executive Board taking place monthly with a formal agenda, these continued through the pandemic and were led by Andrew Goodall. In addition, regular national calls involving NHS Chief Executives or their deputies, were put in place by Andrew Goodall, usually weekly, to enable him to have operational oversight of the NHS and ensure system issues and pressures were visible across Wales. I attended these on a 'as required' basis.

15. The papers for the monthly meeting were prepared and held by Andrew Goodall's team and not by my office. The weekly calls were not formally minuted but I believe someone in Andrew Goodall's office took some informal notes for reference. My office did not take any notes and were not provided with copies of any notes taken.

Public health role – advocate for the people of Wales

16. Prior to the pandemic I used my annual reports as a way of bringing important public health issues to the attention of the Welsh Government and the public. For example, my annual report for 2016/2017 included a discussion about the public health concerns associated with gambling – "*Gambling with our Health*" (**FAM2BCMO/01 – INQ000066188)**. The 2018/2019 Annual Report – "*Valuing our Health*" considered threats to the health of the people of Wales. In the introduction I noted that "*We live in an inter-connected world and recent events, such as the rise in cases of measles across Europe, new and importable diseases such as Ebola and Monkeypox, and the use of chemical agents all serve to remind us that we ignore health protection arrangements at our peril. I will be looking further at ways in which we need to strengthen this aspect of our public health system*" (**FAM2BCMO/02 – INQ000066189**).

17. During the pandemic I addressed the Welsh public in a variety of different ways: appearing at the press conferences with the First Minister; providing radio/TV interviews and issuing public messages from the CMO(W) office. My 2019/2020 Annual Report – "*Protecting our Health*" was in the form of a Special Report on the pandemic between January 2020 and August 2020 (**FAM2BCMO/03 – INQ000066190)**. My Annual Report for 2021/2022 – "*Restoring our Health*" considered how the health of the Welsh people had been affected by the pandemic between January 2021 and October 2021 (**FAM2BCMO/04 – INQ000048783**). In that report I set out the disproportionate effect that the pandemic had had on disadvantaged groups and considered how we could work towards restoring the nation's health.

CMO(W) office

18. There has been a separate CMO for Wales since 1969. Prior to that, there was one CMO covering both England and Wales.

19. As CMO(W) I am supported by a Deputy Chief Medical Officer ("DCMO"), Dr Chris Jones. Dr Jones deputises for me during any absences and also has a lead role in

supporting the health service quality, safety and effectiveness aspects of the CMO role in Wales. In April 2021 an additional DCMO, Dr Gill Richardson, was appointed to lead on issues related to vaccination. Prior to taking up this role Dr Richardson had been on secondment to Welsh Government from Public Health Wales as a Senior Professional Advisor to the CMO(W). Her role as advisor to the CMO(W) included general support on public health issues, maintaining effective relationships with Public Health Wales, and helping to coordinate the efforts of Welsh Directors of Public Health.

20. Prior to the pandemic, the CMO business unit consisted of an SEO NR and an HEO NR Support was brought in throughout the pandemic, but NR NR and NR provided administrative support to me throughout. An explanation of the Civil Service grading is provided at **FAM2BCMO/05-INQ000066193.**

21. When the demands on me increased dramatically in February 2020 with the constant updates and activity around the pandemic I was aware that there was insufficient administrative support in the CMO(W) private office to manage the sheer volume of correspondence and information coming in and being requested. This was not surprising. Prior to the pandemic, the CMO(W) private office consisted of a HEO (SEA) role (NR and an EO role NR). Shortly before the start of the pandemic NR took partial retirement which meant her dropping from HEO/SEA grade to TS/PA grade while continuing in the same role. The pandemic put an unprecedented level of pressure on the CMO private office and the wider Health Protection Team. I raised this lack of sufficient administrative support with the Director General for HSSG, Andrew Goodall, and some additional support was eventually provided.

22. Additional administrative support was provided in May 2020. NR joined my private office as my Principal Private Secretary (Grade 7) and she brought in ad hoc support from NR (SEO) and NR (HEO) to support the existing team of EO and PA. This additional support was on a temporary basis. The unprecedented demands of the Covid-19 pandemic remained a constant pressure on my office and the Health Protection Team as outlined in a letter to the Director General for HSSG on the 10 August 2020 set out in **FAM2BCMO/06-INQ000066192**. As I have set out in this letter, I expected to see significant resurgence over the next few months in keeping with international experience. I raised concerns not only with internal Welsh Government resources, but also with Public Health Wales NHS Trust ("Public Health

Wales") resources as well but noting that Public Health Wales had funding to recruit additional communicable disease consultants. Public Health Wales had proved itself adept at managing community outbreaks and incidents but the organisation was in my opinion over-stretched, and key gaps in supporting settings based outbreaks had emerged, for example in closed settings such as care homes, schools, prisons, and industrial sites, where the nature of the settings required more tailored situational advice and guidance. I was concerned that they would not be able to respond to a very significant increase in infection rates if we saw multiple outbreaks in various settings as was occurring in other parts of the UK.

23. I particularly raised concerns that there was an expectation for resources within the HSSG to be used to perform new functions such as the Wales Covid-19 Vaccination Programme, the Coronavirus Intelligence Cell and the enhanced Health Protection Advisory Group. I was concerned that the exceptional efforts by staff in the OCMO(W) that had been made to manage and mitigate the impact of the virus was largely unseen and was unsustainable due to the demand and the unexpected length of the pandemic.

24. Following my letter, I met with Andrew Goodall to discuss these concerns so no formal response was provided as confirmed in exhibit **FAM2BCMO/06A-INQ000353108** and **FAM2BCMO/06B-INQ000353147**. Andrew agreed with the overall concerns I had raised noting that some would need to be dealt with inside and others outside the organisation. I recall being content with the response from Andrew which is why I confirmed a formal response was not required and I felt his response was commensurate with the seriousness of the concerns I had raised.

25. Public Health Wales redeployed staff to support the response in the coming months. My recollection is that the concerns or key gaps were addressed adequately and did not give me cause to raise the issue with Andrew Goodall again.

26. In terms of my own office, while NR and NR both returned to their roles in October 2020 NR joined my private office in October 2020 as an Assistant Private Secretary (HEO) on a permanent basis. NR also joined the private office in November 2020 as a Private Secretary (SEO). NR left the office in March 2021, arranging for me to have temporary support from Gemma Nye (who was a deputy director at the time) from February 2021 to August 2021. NR moved to the Vaccination team in January 2022 and NR left the private

office in February 2022 to join a policy team leaving my private office consisting of NR and NR to the end of the specified period.

27. This meant that from May 2020 until February 2022 I had more support. While this team of excellent civil servants proved invaluable as the demands of the pandemic increased, on reflection it would have been helpful to have that resource sooner in the initial period January/ February to around March/ April 2020. This did not impact on my capacity to process and understand the information received, in particular that of a scientific or complex nature or my ability to advise the Welsh Government or the NHS in Wales. The issue was administrative support to address the volume of meetings and emails and ensure I had the right meeting information in my calendar, the most up-to-date papers for meetings and that there was some sort of system for logging information coming into my office. I also did not have administrative support within my office to accompany me to informal meetings and take notes on my behalf. This meant that for informal meetings with ministers, officials or the NHS I do not have contemporaneous comprehensive notes of the discussion. I did where possible take informal notes, jot down actions, or points of interest in my notebooks which are not part of the formal Welsh Government record but are available to the Inquiry.

28. In terms of technical expertise and support there was not a lack of this, we had a number of public health consultants brought into assist on that front. I am also supported in my role by a Health Protection Team and a number of Health Professional Leads. The personnel in this group changed from time to time with health professionals being brought in based on their experience and expertise and what this could bring to the work of the CMO office at the particular time NR (G7) was seconded from Public Health Wales from May 2020 until April 2022 as a Public Health Policy Advisor to provide public health policy support and would also support me directly as well as the public health team.

29. As well as my CMO(W) role, I am also the Director of the Population Health Directorate which is a part of Welsh Government's HSSG. The directorate has responsibilities around health protection, health improvement for the Welsh population, health and care research which Welsh Government commissions and supports, and (up to April 2022) health service quality and effectiveness.

2: Covid-19 and Sources of information and advice

30. Covid-19 is a disease caused by a new type of coronavirus named SARS-CoV-2. In the UK we had some previous experience of coronaviruses in the form of severe acute respiratory syndrome ("SARS") and the Middle East respiratory syndrome ("MERS"), but Covid-19 was different. My background is not in virology or epidemiology, and given how quickly knowledge and understanding of Covid-19 was changing, the consistent approach that I took during the pandemic was to ensure that the Welsh Government was always provided with the evolving scientific knowledge of Covid-19 and how it was affecting Wales and the UK, as well as the emerging international experience and evidence in order to inform its decision making.

31. As outlined above my understanding of the virus was very much informed throughout by the UK CMOs sources and understanding. A detailed summary of the UK CMO's understanding and how it developed during the specified period is provided in Chapter 1 of the Technical Report on the Covid-19 pandemic in the UK prepared on a joint basis and exhibited in **FAM2BCMO/07 - INQ000177534.**

32. To ensure I understood the expert and scientific advice regarding the transmission, infection, mutation and reinfection, I relied on expertise and information from colleagues such as the other UK CMOs, the senior clinicians group, those in the Scientific Advisory Group for Emergencies ("SAGE"), the Technical Advisory Group ("TAG") in Wales and Public Health Wales. Particularly in the early stages of the pandemic there was flurry of information coming into Welsh Government and into my office taking the form of various government department four nation meetings, inputs from the World Health Organisation, Public Health England, NHS colleagues and the wider scientific medical community as well as from our Welsh Government policy officials. On top of that, we had Ministerial Implementation Groups ("MIGs") (I attended the Healthcare MIG) and COBR meetings which helped to form the four nations picture alongside the CMOs meetings and Senior Clinicians Group meetings.

33. In respect of understanding death rates, the certification of cause of deaths and excess mortality in Wales, I had information from the Office of National Statistics, the NHS in Wales and access to the data expertise of the Chief Statistician for Wales.

34. In terms of providing Welsh Ministers with advice on the public health implications of Covid-19 and the measures implemented to deal with it, I pulled together inputs from principal sources of data which are detailed below. These were the sources I would frequently rely on to inform my advice to the Welsh Ministers but were not by any means the only information sources coming into the CMO(W) or indeed into the Welsh

Government. In terms of advice on the statistical confidence in the underlying data, modelling or science I did not routinely convey this to Ministers where a consensus or agreed view was reached by the source providers. Apart from in the case of the UK CMOs, I was not routinely appraised of divergent opinions or the nuances of academic discussion within SAGE or TAG which preceded an agreed position or consensus view.

35. I have detailed the key sources of information below in more detail. This expertise on transmission, infection, mutation, reinfection, death rates, the certification of cause of deaths and excess mortality in Wales was provided via meetings, telephone calls and emails.

36. I did not use WhatsApp or text as a means of regular communication with the sources identified below save for in the case of the four UK CMOs. The UK CMOs have WhatsApp Groups which were used to coordinate diaries or give notice of urgent meetings. Aside from checking meeting availability, this WhatsApp group was also used as a space for social interaction and mutual support and information, but it was not used for policy decisions. I do not have copies of all of the WhatsApp messages from this group as my previous phone ceased to function in 2021 so any messages in my possession are from 2021 onwards. I would occasionally exchange messages with Andrew Goodall but again these mainly were for mutual support or confirming meeting information. I understand these messages have been disclosed the Inquiry.

<u>UK wide sources</u>

CMO discussions

37. One key source of information throughout the pandemic was via the other three Chief Medical Officers ("the UK CMOs") in the UK with whom I had excellent working relationships. Prior to the pandemic, the UK CMOs tended to meet quarterly with the chair of the meeting being rotated. Professor Chris Whitty became CMO for England and Chief Medical Adviser to the UK Government in Autumn 2019 and from then a more informal approach to meetings was adopted by convening the UK CMO's whenever we had something to discuss.

38. As CMOs our role is very much to think about the risks to people's health and think about what is potentially coming down the line. We had of course seen other significant outbreaks before, for example the H1N1 flu pandemic of 2009 so always

knew there was a possibility of a new pandemic and we were mindful of looking for potential threats.

39. I had first heard of the novel coronavirus sometime between Christmas 2019 and the New Year and we, the UK CMOs, had some high-level discussions about what was happening in China but it was still very much contained in China at that point. The Deputy CMO in England, Dr Jonathan van Tam was monitoring the situation and keeping the UK CMOs up to date with developments. He or Chris Whitty would update the UK CMOs ar our meetings. I did not have bilateral meetings with Dr Van Tam or direct emails or other forms of communication (such as text or WhatsApp messages) from him. All communication I received was to the UK CMOs.

40. In those early days of January 2020 our assessment of the situation was that the outbreak which was occurring in Wuhan could have three potential outcomes: it could just fizzle out, it could lead to limited regional spread in other Asian countries, or it could become a more widespread global issue. Our early view, based on the experience from SARS was that it would most likely fizzle out or be limited to Asia. We did not provide or formulate advice as to the approach for each of these three possible outcomes but remained alert to the possibility of all three. In the case of it becoming a more widespread global issue the four CMOs would consider the approach alongside the influenza planning assumptions and the emerging data on the virus, which is what we ultimately did.

41. On Friday 24 January 2020 Chris Whitty convened a UK CMOs call about 'Wuhan coronavirus'. The meeting on the 24 January had followed a CMO alert issued the day before (23 January 2020) by Chris Whitty which was copied the UK CMOs. It was from around this time that Covid-19 was discussed as a real potential threat to the UK.

42. This meeting on the 24 January 2020 was the start of a regular pattern of very frequent and sometimes daily meetings for the first few weeks of the pandemic.

43. The UK CMOs meetings were chaired by Chris Whitty and his office acted as secretariate but if they took minutes or notes, these were not shared with the other UK CMOs so there is no agreed record of the meetings. I would occasionally take informal personal notes or note any actions for CMO(W) office, but these were for my own personal use and never added to the Welsh Government record or circulated. Overall, the meetings were quite informal, and we did not have papers or agendas circulated in advance. These meetings then continued on an ad hoc basis, sometimes up to 3

times a week, before we settled into a rhythm of weekly meetings on Friday mornings from August 2020 and we continue on this basis today with both a review of the Covid-19 pandemic status and scope for wider discussion.

44. In addition to the regular CMO meetings the UK CMOs would also meet to discuss clinical issues at a weekly Senior Clinicians Group and this wider forum helped to maintain good, productive working relationships throughout the pandemic. This was initially an England only group initially but in light of the impact of Covid-19, the other UK CMOs were invited. I do not have formal papers from this group. The UK CMO office determined membership and held information about who attended.

45. Having these sources of professional support during the pandemic, particular in the early stages, was very important to me and one of the really positive aspects of our pandemic management.

Scientific and Advisory Group for Emergencies

46. Although the Scientific and Advisory Group for Emergencies ("SAGE") was convened on the 22 January 2020 on a precautionary basis. I was not formally invited until the 11 February 2020. Due to meeting commitments, it was agreed that the Chief Scientific Officer for Health, Dr Rob Orford would attend SAGE and brief myself and Ministers. Rob Orford continued to attend SAGE on this basis for the remainder of the specified period, occasionally being replaced by his colleague Fliss Bennee, who job shared with him. Dr Orford typically briefed me via email or during video or telephone meetings. We did not communicate informally via text or WhatsApp regarding SAGE.

47. In terms of the discussion at SAGE and how a consensus opinion was reached, I do not recall any specific information concerning divergent views between the members of SAGE. For our purposes in advising ministers and policy officials we needed to know the consensus or agreed opinion.

ONS surveys

48. The Office of National Statistics ("ONS") was also another rich source of data and information. The Chief Statistician engaged with the ONS but given the ONS's expertise in mortality analysis and their privileged position on access to a wide range of data sources, I wrote to the National Statistician in July 2020 (**FAM2BCMO/08 – INQ000066195)** to request analysis of the first wave of the pandemic which explored

the factors that may have influenced excess mortality. In my letter I specifically asked if the data could be analysed to confirm if geographical variation could be explained by other factors including deprivation, health, demography, urbanisation, prevalence of care homes, and occupation mix.

49. TAG provided some advice on this in July 2020 in a report entitled Technical Advisory Group: examining deaths in Wales associated with Covid-19. This is exhibited in **FAM2CMO/09-INQ000252526.** This report confirmed that there were proportionally fewer deaths in Wales than in the UK as a whole during the first wave of the Covid-19 pandemic and fewer than most parts of England. At that time we did not fully understand why this was the case. It was recognised that the highest death rates were in older people, people from Black Asian and minority ethnic backgrounds and deprived communities so there needed to be a continued focus on identifying and protecting the most vulnerable people in society. Men also had consistently higher mortality rates across all ethnic groups. The report confirmed that the majority of excess deaths were due to Covid-19, with a small proportion accounted for by deaths where Covid-19 was involved but was not the underlying cause and a larger proportion, about a third, accounted for by non-COVID-19 deaths.

50. TAG issued a further report in March 2021, as exhibited in **FAM2BCMO/10-INQ000252532.** This confirmed that the level of excess deaths has been largely unchanged in Wales between the two reports whereas it had fallen in Scotland and many regions of England. There was considerable variation within Wales, and the reasons for these different patterns was not yet fully understood but may reflect the different geographical spread of the virus at different points in the year. TAG agreed that further work is required at a UK level to understand the relationship between COVID-19, policy interventions and deaths in each of the four countries, so that we can mitigate as much harm as possible in future waves. The work I requested from ONS was finally published in October 2023 as an academic paper which is exhibited in **FAM2BCMO/10A-INQ000353561.** The analysis focuses on comparisons of excess mortality between the 4 nations of the UK and regions of England rather than an exploration of the factors that may have driven differences in excess mortality.

51. The main findings show:
    i. Across both waves the least affected country or region was the South-West of England and the most affected was London

ii. Across all areas, ages-standardised excess mortality was greater in males than females, this difference became more pronounced in wave 2 (week 37 of 2020 to week 9 of 2021).

iii. In wave 1 Wales (week 11 to week 36 of 2020) had some of the lowest age-standardised excess mortality rates when compared with Scotland, Northern Ireland and the regions of England. However, there was a large increase in age-standardised excess mortality rates from wave 1 to wave 2 for both males and females in Wales. The increase in age-standardised excess deaths from wave 1 to wave 2 was more pronounced for males than females in Wales.

iv. In Wales the male age-standardised excess mortality rate increased two-fold from wave 1 to wave 2. Most areas saw a decrease in female excess mortality in wave 2, the largest fall in the North-East of England. The exceptions were Wales and the East of England. Wales had the largest increase in both female excess age-standardised mortality rate (ASMR) in wave two compared to wave 1.

52. This is a complex piece of analysis and I am pleased that ONS made progress on this topic.

The Joint Biosecurity Centre

53. The Joint Biosecurity Centre ("JBC") was established by the UK Government to provide evidence-based, objective analysis, assessment and advice to inform local and national decision-making in response to Covid-19 outbreaks. This operated on the basis of a four-nation partnership and provided inputs at different levels into Welsh Government. The JBC had a Technical Advisory Board which included the UK CMOs and the JBC informed the UK CMOs advice on the UK alert levels.

54. Formal notes of this meeting were taken by the UKHSA. Some information my be retained in my emails but this will not be comprehensive.

55. I do not recall any occasions when I took a different view to the views expressed by the JBC. In terms of divergent views generally amongst the Technical Advisory Board, again specific instances do not stand out to me and would be unlikely to have been reflected in advice to the Welsh Government. The main 'product' from my attendance at this Board was the UK CMO advice on the UK alert levels. That advice would be communicated to the Welsh Government.

Welsh sources

Public Health Wales

56. The role of Public Health Wales was significant throughout the pandemic and it provided an important source of information and advice both in terms of scientific, technical expertise but also in terms of the wider impacts of Covid-19 in Wales. Public Health Wales is the national public health agency in Wales and its statutory functions are to provide and manage a range of public health services relating to the surveillance, prevention and control of communicable diseases. It also develops and maintains arrangements for making information about matters related to the protection and improvement of health in Wales available to the public in Wales and undertakes and commissions research into such matters as well as undertaking the systematic collection, analysis and dissemination of information about the health of the people of Wales. Given Public Health Wales's statutory functions and my role as CMO(W) and Director of Population Healthcare prior to the pandemic we worked closely and this continued and developed during the pandemic.

57. Public Health Wales issued or assisted Welsh Government policy officials to develop and issue guidance for Covid-19, particularly in respect of infection prevention and control ("IPC") advice which was essential throughout the pandemic period. In addition, Public Health Wales also provided a wealth of data via their Public Engagement Survey which they started conducting around April 2020. Each week, Public Health Wales would conduct interviews with people across Wales, to understand how Covid-19 and the measures being used to prevent its spread were affecting the physical, mental and social wellbeing of people in Wales. The outcome of this survey would be provided to the Welsh Government's Knowledge and Analytical Services team and provided an important insight into the impact of the Welsh Government's response to Covid-19.

58. Public Health Wales provided advice directly to the HSSG and the Welsh Government's Technical Advisory Cell but I would also meet with Public Health Wales colleagues regularly. This was ad hoc in February but from March 2020 we developed a rhythm of twice weekly check-ins or catch-ups with Public Health Wales, some with the Public Health leads or with the Chief Executive, Tracey Cooper, and with some additional ad hoc meetings if there were specific issues to discuss. These then found a rhythm of weekly meetings from September 2020 to December 2021 and now still

take place monthly with a wider scope in 2022. These are informal and no agenda or papers are attached to the check-in.

59. Public Health Wales also provided my office with regular Public Health Advisory notes. Some of this advice was commissioned by myself or my office but Public Health Wales would also send me unsolicited public health advice at times as well if there were matters they were working on or had intelligence from their networks. Any advice was considered and if appropriate incorporated into my advice, be it verbal or written to Ministers.

60. Due to administrative constraints, we do not hold a formal log of commissions to Public Health Wales from myself or my office. Requests for advice may have come via email, telephone calls or during meetings.

Welsh Government's Technical Advisory Cell

61. Rob Orford and I agreed right at the beginning of the pandemic that a technical and scientific advisory cell within Welsh Government was required in order to provide advice to officials and Ministers which was specifically tailored to Wales. On 27 February, the Welsh Government established a Technical Advisory Cell ("TAC"), which is chaired by the Chief Scientific Adviser for Health. TAC provided scientific and technical information interpreted for Wales in adherence to advice provided by the UK Scientific Advisory Group for Emergencies ("SAGE") for Covid-19. The TAC worked alongside the Technical Advisory Group ("TAG"). Membership of TAG included experts from Welsh Government and Public Health Wales.

62. The first TAG meeting was held on 3 March 2020. The Terms of Reference are set out in **FAM2BCMO/11– INQ000177396.**

63. The SAGE briefings that Rob Orford was providing to me became 'TAC briefings to the CMO(W)'. The TAC briefings very much informed my advice to Ministers as set out in Cabinet meeting papers and recorded in minutes.

64. TAC would also provide advice for Ministers and public facing reports as well. TAC, in addition to the information coming from SAGE, were receiving data from a variety of sources to inform their reports and briefings. I would also routinely review the TAC advice and reports and provide comments where appropriate, but I would not routinely review all the data sources used to compile the advice. I did not regularly attend TAG

or TAC meetings but had regular informal catchups and email exchanges with both Rob Orford and Fliss Bennee.

65. In formulating my advice to Ministers, bringing together the expert, medical and scientific evidence and data and statistical modelling I would seek to summarise this as concisely as possible. The regular advice to Ministers from TAG usually included the level of confidence for any conclusion. Scientific and modelling work was often presented to Ministers without amendment, so included all academic caveats and discussion of study limitations.

66. The information flows from TAG and TAC were the primary source of expert, medical and scientific advice to the Welsh Government and this was cascaded down to other key bodies and organisations such as Public Health Wales, NHS bodies and local authorities in Wales (**FAM2BCMO/12– INQ000068507**).

67. Subgroups of TAG were also developed to support the wide range of stakeholders across Wales, including specific sub-groups covering:

    i. Risk and Behavioural Communications

    ii. All-Wales Modelling forum, to support the work of planners within the NHS

    iii. Research

    iv. International evidence

    v. Wider socio-economic harms

    vi. Testing

    vii. Children and Schools

    viii. Environment Modelling.

Knowledge and Analytical Services

68. From early April 2020, statisticians in the Welsh Government's Knowledge and Analytical Service ("KAS") compiled a regular "data monitor". This was developed in recognition of the need for a single document containing a rounded view of data covering all aspects of the pandemic to support multiple audiences – such as myself, TAC, Ministers and senior policy officials. The monitor brought together the latest data

on the pandemic and provided a concise and timely way to advise Ministers and senior officials on the latest figures and trends. The monitor drew on a wide range of the data sources set out in the earlier part of this statement and covered the following themes:

i. Cases, deaths and vaccinations

ii. Health and social care

iii. Shielded and vulnerable people

iv. Attitudes and behaviours

v. Economy and labour market

vi. Public services

69. The monitor, or a version of the monitor was also later shared with external bodies such as the Police and Crime Commissioners and the Joint Military Command Wales Intelligence Cell. The monitor was generally updated on a weekly basis. This work was led by the Chief Statistician for Wales who I would meet with informally on a regular basis to receive a brief on latest statistical developments or to help to inform any papers I was reviewing or producing myself.

Modelling data

70. During the pandemic modelling data was essential to inform the advice to Ministers. While I would receive modelling, the structures and processes which were utilised or developed for the consideration, discussion and provision of advice about data and modelling was led by the Chief Scientific Adviser for Health, Rob Orford and his team. I was not involved in the commissioning that data. TAC and TAG provided scientific advice and modelling to inform the pandemic response, often drawing on data collected by KAS, but also utilising data from the UK Government's Scientific and Advisory Group for Emergencies ("SAGE").

71. Updates from the CSAH from SAGE also included information coming from the Scientific Pandemic Influenza Group on Modelling ("SPI-M-O"), a subgroup of SAGE. SPI-M-O allowed for an expansion in the number of academics providing support to the government response and increased the diversity (of models, modelling approaches, data and assumptions used, experience, academic institutions) of the

group, and for a wider range of observers from government departments and the devolved administrations to attend and understand the principles and evidence derived from modelling. This was attended by Fliss Bennee who was part of the CSAH team and worked closely with the CSAH on a job share basis.

72. SPI-M-O acted to draw together results and insights across the various individual models and the significant expertise and experience of its participants to provide a consensus position. SPI-M-O was the main structure and process used for the consideration, discussion and provision of advice about data and modelling. This scientific evidence was then used to inform SAGE advice and TAG advice which was then used to inform policy.

73. Generally, SPI-M-O (and SAGE) took a UK-wide approach to Covid-19. As policy development considered different spatial scales and as the epidemic spread at different speeds across the UK, models that considered different nations, regions or even smaller geographical areas became more and more useful. Dialogue between UK-wide and devolved administration modelling efforts continued throughout the pandemic. As noted above Fliss Benee participated in SPI-M-O and reported to the CSAH. Additionally, there was also an All-Wales Modelling forum, to support the work of planners within the NHS and the work of SPI-M-O was fed into this group as well.

74. In terms of expert, medical and scientific information, data collection, and statistical modelling which was specific to Wales, Public Health Wales led on the collection, analysis and dissemination of rapid surveillance data for Covid-19, covering topics such as test positivity, case rates, deaths and vaccination uptake.

75. NHS Wales also worked with a number of academic partners to deliver the response to Covid-19. A number of Welsh academics also participated in the Technical Advisory Group and its sub-groups working closely with NHS Wales and Welsh Government officials and technical advisors. Additionally, the Secure Anonymised Information Linkage Databank (SAIL Databank) which is run and owned by Swansea University. provided an intelligence led approach to Covid-19 data to inform the response. Modelling was produced by Swansea University using the SAIL databank information and provided to TAG. The SAIL Databank received funding support from Health and Care Research Wales and UK Research and Innovation's (UKRI) Economic and Social Research Council (ESRC).

<u>International sources</u>

76. The CMO(W) office had an international network/source of information which we also drew upon, this included colleagues in the Welsh Government Culture, Sport and Tourism Directorate who also had a number of non-clinical international networks providing information on the impacts of measures in other countries. I myself had worked in many different countries so have an informal clinical network/contacts generally who I kept in touch with to discuss areas of professional medical interest rather than advice.

77. We, through a variety of routes, had bilateral discussions with a number of countries to try to understand how the epidemic was unfolding in other parts of the world and to see what we could learn from those countries. From my recollection, I participated in discussions with colleagues in South Korea, Germany, Italy and in Sweden. These were informal chats but were invaluable, because every country has a slightly different perspective and slightly different response and so comparing approaches was important. However, while those bilateral relationships were really useful, we needed a more systematic approach to understanding what is happening across other countries.

78. We did have some extremely good links via Public Health Wales which were made through the International Association of National Public Health Institutes ("IANPHI"), of which Public Health Wales is a member. We also have some links, with the World Health Organisation ("WHO"). These were informal meetings and no formal note was taken.

79. Later during the pandemic, the Covid-19 International Comparators Joint Unit Data Team (a joint unit between Cabinet Office and the Foreign, Commonwealth and Development Office ("FCDO")) was also a good source of international data. The FCDO and Cabinet Office used international data, including from the FCDO's overseas network, to provide analysis of different countries' responses to the crisis. The FCDO analysis was shared widely across government departments and with the Devolved Governments to inform policy decisions. The main link of this information to Welsh Government was via Rob Orford and SAGE.

80. The evidence from other countries was helpful in advising Ministers on the pace of lifting restrictions. For example, in May 2020 the cautious approach to lifting restrictions in Wales was seen as proportionate, as evidence from other parts of the world, such as Korea, Germany and Singapore, demonstrated that relaxing measures too soon and too quickly had led to a resurgence in viral transmission. The exchange of information on the approaches by other countries was invaluable in helping inform

our understanding of the virus and the medical, scientific and operational approaches being taken but this was just one part of a wide range of information and data sources used to help inform decision making by Welsh Government.

Assessment of the data received by the CMO office

81. As outlined above there were numerous data sources throughout the pandemic which we relied on to inform advice to Ministers and officials. Overall, there was a lot of information that was available but the most significant point was that this was a new virus. We were learning constantly and having to adjust the response accordingly, particularly in the early part of the pandemic. Our knowledge and understanding of the virus changed rapidly and we needed to respond at pace to this ever-changing context.

82. In terms of advice which I did not have access to that I considered important I cannot recall any specific examples of this. I did not make any requests for access to data which were refused. As outlined above I did request ONS to undertake analysis of mortality rates which would have been helpful in aiding understanding of broader health inequalities and harms of Covid-19. The delay in receiving this data and information did not impact on the advice given by my office to the Welsh Ministers, particularly in respect of NPIs.

Impacts of Covid-19 decision making

83. In broad terms my advice was based on an assessment of how any amendments to the restrictions would impact on the four harms of the pandemic which had been articulated by Chris Witty, the CMO for the UK. The four harms were as follows:

    i. direct harm to individuals from SARS-CoV2 infection and complications including for those who develop severe disease and in some cases sadly die as a result;

    ii. indirect harm caused to individuals if services including the NHS became overwhelmed due to any sudden large spike in demand from patients with Covid-19 on hospitals, critical care facilities and other key services;

    iii. harms from non-Covid illness, for example if individuals do not seek medical attention for their illness early and their condition worsens, or more broadly from the necessary changes in NHS service delivery made during the pandemic in Wales to pause non-essential activity; and

iv. socioeconomic and other societal harms such as the economic impact on certain socioeconomic groups of not being able to work, impacts on businesses of being closed or facing falling customer demand, psychological harms to the public of social distancing and many others.

84. A fifth harm was added to the list formally in Wales: (v) the way Covid-19 has exacerbated existing or introduced new inequalities in our society. These five harms were considered as part of the 21-day review process which I outlined in more detail later in this statement under the heading "Decision making by the Welsh Government relating to the imposition or non-imposition of NPIs".

85. In relation to socio-economic harms the Chief Economist for Wales, Jonathan Price would provide Cabinet with advice on the broader picture in Wales. For example, provided regular updates on the economy at Cabinet meetings, as and when required. I exhibit by way of example a paper submitted by the Chief Economist prepared for Cabinet, dated 4 June 2020, setting out Wales's economic prospects in the wake of Covid-19 (**FAM2BCMO/12A-INQ000129875**) and minutes of the Cabinet meetings that took place on 28 September 2020 (**FAM2BCMO/12B-INQ000048928**) and on 22 February 2021 (**FAM2BCMO/12C-INQ000057892**) at which the Chief Economist provided advice.

86. Additionally, as outlined above the Technical Advisory Group had a number of dedicated sub-groups who would feed into the advice provided by TAG. For example the Socio-Economic Harms sub-group, chaired by the Chief Economist provided information to TAG which I understand was reflected in the advice that was provided to by the Chief Scientific Advisor for Health to myself (TAC briefings) and to Ministers.

87. In my advice I would confirm that my advice was informed by the outputs of the UK Scientific Advisory Group on Emergencies (SAGE) and the Welsh Technical Advisory Cell (TAC), and through discussions with Chief Medical Officers in the 4 Nations and the Chief Economic Advisor in Wales. An example of this is exhibited in **FAM2BCMO/12D – INQ000353089.**

88. While we considered the imposition or non-imposition of NPIs in relation to these "harms" it would not be the case that for every change or at every 21-day review that there would be all five harms to mitigate against. Where a particular harm was relevant to the decision before the Ministers I would highlight this in my advice.

89. Infectious disease modelling is not a tool that can balance direct disease burden with other harms, such as the economic and social impacts of policy decisions or interventions. I addressed these issues in my Special Report published in January 2021 (as exhibited in **FAM2BCMO/3 – INQ000066190** above).

90. In that report I noted that no-one could have been prepared for the devastation that the Covid-19 pandemic would bring, some people were more vulnerable to its direct and indirect effects than others. This became increasingly evident during the first phase of the pandemic as our understanding developed that Covid-19 was harming people (principally in four ways, as described in more detail later in this statement at paragraph 136) and exacerbating pre-existing inequalities and inequities in our society.

91. During the first phase of the pandemic, it became increasingly evident that Covid-19 was disproportionally affecting the health of people from more deprived backgrounds. In Wales, there has been evidence of a socioeconomic gradient in hospitalisations and deaths. Data showed that the age-standardised rate for admissions to hospital for Covid-19 in the most deprived quintile (fifth) was around twice that of the least deprived quintile. Intensive care data for Wales have also shown that there was a greater proportion of patients in critical care with Covid-19 from the most deprived quintile than other quintiles. Additionally, the mortality rate involving Covid-19 in the most deprived areas in Wales was nearly twice as high as that in the least deprived areas, with 121.4 deaths per 100,000 people in the most deprived quintile, between March to July, compared to 65.5 deaths per 100,000 in the least deprived areas. Analysis from England has similarly shown that people living in deprived areas had both higher diagnosis and death rates from Covid-19.

92. Informing this special report were reports from the Technical Advisory Cell, Office of National Statistics, Public Health England, the Centre for Evidence-Based Medicine and British Medical Journal all of which are referenced in the report.

<u>Differences in expert opinion</u>

93. As outlined above we were constantly learning about the virus and adapting the response to account for that learning and understanding. What was important however, from a medical or public health perspective is that we considered any changes within the hierarchy of controls, which is a widely recognised systematic way to identify, eliminate or reduce risks.

94. The hierarchy of control outlines five levels of control in order of effectiveness, which are:

    i. Elimination
    ii. Substitution
    iii. Engineering controls (control, mitigate or isolate people from the hazard**)**
    iv. Administrative controls (change the way people work)
    v. Personal protective equipment (PPE)

95. All four nations would also have considered the hierarchy of controls and decisions on what measures to use when applying the five levels of controls varied between nations at different times. Ultimately decision makers, which at a national level were the ministers and at a local level NHS leaders, social care providers and employers, considered the situation and decided which measures were appropriate.

96. One area there was a difference in opinion is when it was necessary to apply the fifth level of control for the general public. PPE for frontline staff was identified early as a requirement to reduce risk to frontline staff. From around April/May 2020 there were increasing calls for mandating facemasks in the community. I kept the evidence under continual review and was strongly supportive of the use of face masks in clinical settings, but there was less clear evidence around face coverings in non-clinical settings. The public discourse did not always clearly distinguish between facemasks (medical) and face coverings.

97. On the 11 May the UK Government had advised the public to consider wearing face coverings in enclosed public spaces such as shops, trains and buses to help reduce the spread of coronavirus. Chris Whitty had publicly confirmed his view that wearing a face covering is an added precaution that may have some benefit in reducing the likelihood that a person with the infection passes it on.

98. I issued a statement on the 12 May 2020 in respect of face coverings in which I confirmed that I did not recommend the compulsory wearing of face coverings by everyone when they leave home and indicated that this should be a matter of personal choice. In this respect I did differ from the views held by the other CMOs. A copy of this statement is exhibited in **FAM2CMO/13- INQ000048738.**

99. I was concerned that at time of the statement PPE stocks were in high demand and the priority was ensuring sufficient supplies of medical grade facemask for hospital and care staff. Secondly, use of masks could promote risky behaviours. Anyone with

symptoms should have remained at home and using a face covering to go shopping or to work did not change that. I was also concerned that the face coverings being used in the UK did not generally meet standards defined by the World Health Organisation and there was an important equity issue regarding the ability of everyone to either buy a mask or make one. In Wales we applied the model of the "hierarchy of controls" and concluded that the most effective way to interrupt viral transmission was to promote social distancing and I was clear that our messaging should focus primarily on encouraging that behaviour.

100. Early in June 2020 the MHSS and First Minister requested advice on face coverings, particularly in light of requirements being introduced in England mandating the use in hospital settings and on public transport.

101. TAG advice in on the use of face coverings was received in June 2020. A copy of this is exhibited in **FAM2CMO/14- INQ000066278**. This particularly highlighted that face masks and face coverings are different, and this difference should be emphasised in advice given to the public, and a consistent use of vocabulary ensured in communications from government. 'Face coverings' is an alternative term for a "non-medical mask" as referred to in the WHO guidance.

102. I provided advice to Ministers in June 2020 which reflected on the WHO guidance and the advice from the NTG, chaired by the DCMO. A copy of the advice to First Minister is exhibited in **FAM2BCMO/15 – INQ000281742**. This advice confirmed that WHO guidance noted that there was no new evidence that everyone in hospital or care settings should wear masks but that WHO had moved to recommending the wearing of non-medical face coverings in the community by the general public but also emphasised that the use of a mask alone is insufficient to provide an adequate level of protection or source control and other person and community level measures should also be adopted to suppress transmission. I remained of the view that the evidence of benefits did not justify a mandatory or legislative process and I saw dangers in taking such an approach for Wales. I stated that non-medical facemasks could be recommended in public transport or shops if overcrowded (thereby making social distancing difficult).

103. On the 9 June the MHSS recommended use of 3-layer face masks in Wales by the general public but did not make them mandatory. From the beginning of 27 July 2020 there was introduced a new legal requirement to wear face coverings on public transport. My office met with legal advisors to make the point that any mandatory face

coverings should be 3 layers (as recommended by the World Health Organisation) but there were issues about enforcement if this were to be legislated.

104. My office did engage on ensuring that the reasonable excuse for not wearing face coverings was clear in guidance so that people with physical or mental illness, or if accompanying someone who relied on lip reading or if escaping a threat or danger did not need to be concerned about wearing a face covering. We also ensured that the guidance was clear that the best form of protection was from a minimum of 3 layers covering the nose and mouth. A copy of the guidance issued by the Welsh Government on face coverings is exhibited in **FAM2CMO/16- INQ000082634**.

105. A further updated TAG advice was issued on the 11 August 2020 which confirmed that the most recent NERVTAG paper suggested that face coverings were likely to have some benefit in reducing the risk of aerosol transmission. Face coverings were noted to reduce the dispersion of respiratory droplets and small aerosols that carry the virus into the air from an infected person. They also provide some protection for the wearer against exposure to droplets but less protection against small aerosols. A copy of this TAG advice is exhibited in **FAM2CMO/17-INQ000228031**.

106. The First Minister subsequently issued a statement on the 11 September 2020 confirming that from Monday 14 September, all residents in Wales over the age of 11, would be required to wear face coverings in indoor public spaces, such as shops. I did not provide advice on this decision. A copy of the advice provided by the DCMO, Chris Jones, on the 10 September 2020 is exhibited in **FAM2BCMO/18-INQ000281839.**

107. Throughout the remainder of the pandemic period the rules around face coverings and settings in which they applied changed. The hierarchy of controls continued to be applied when making decision on the use of face covering and as we moved slowly out of the pandemic the application of the hierarchy of controls shifted from a national level, determined by ministers, to a local level where NHS leaders, social care providers, local authorities and employers applied the levels of controls. The Welsh Government provided guidance in relation to this as set out in exhibit **FAM2BCMO/19-INQ000253729** for the education and childcare settings and for health and care settings across all four nations in the IPC guidance exhibited in **FAM2BCMO/20-INQ000271659.**

108. While I have referenced face coverings as a point of difference, I would highlight the UK CMOs often had long discussions about differences and were all free to express

their views and debate. An example, more for later modules, would be around the advice on the vaccination of children under 15. The Joint Committee on Vaccination and Immunisation recommendation was that there was no major benefit to mortality rates by vaccinating under 15-year-olds. I recall a long discussion between the CMOs about this and the impact on education. Intense conversation about these issues was commonplace but we would all try to arrive at a common position. A four nations approach was always the ambition and discussion generally achieved this, but we would only provide advice and there was always the opportunity for ministers in each of the four nations to take a different view or decision.

109. In terms of other advice coming to me from SAGE or TAG, I am sure there was discussion before any consensus or agreed position was reached, as in the case of the four CMOs, but I was not in attendance or involved in those groups so was not provided with the nuances of any discussion.

3: Communication and dissemination of advice to the Welsh Government and NHS Wales

110. All of the sources of information set out above informed my approach to the pandemic and the constantly shifting public health crisis. My role as adviser to the Welsh Ministers and the Welsh Government and as Medical Director of the Welsh NHS with a role in coordinating the response of the LHBs took many different forms during the pandemic as set out below.

Cabinet Office Briefings

111. In February 2020 I started attending the 'COBR' meetings on an ad hoc basis, either with the Minister for Health and Social Services ("MHSS") or with the First Minister ("FM"), or on some occasions with them both together. There were sporadic COBR meetings up until May 2020 and then they died down. I do not hold any formal papers or notes from COBR meetings or from any pre-meetings or post COBR discussions with the attending minister.

112. In terms of whether there were sufficient COBR meetings or the usefulness of the meetings to inform my advice to ministers this is a matter for ministers to address. The COBR meetings are for Ministers to share information and make decisions. My role was to support the MHSS and FM with information and analysis prior to the meetings or during and to discuss from a public health perspective any action that Welsh Government needed to take in light of the information from those meetings. In broad

terms my view would be that COBR meetings served more as an information sharing vehicle for UK Government than as a joint decision-making forum.

Health and Social Services Group Coronavirus Planning and Reponses Group

113. A new group was established in February 2020, the Health and Social Services Group Coronavirus Planning and Reponses Group ("Covid-19 Planning and Response Group"). The Covid-19 Planning and Response Group brought together strategic representatives of the Health and Social Services Group ("HSSG") of Welsh Government, NHS Wales and Social Care. The terms of reference are set out in **FAM2BCMO/21- INQ000066198**. Its role was to consider the latest reasonable worst case scenario for Covid-19 risk assessment, co-ordinate contingency response planning across HSSG, share information and communications to raise awareness on contingency arrangements and actions and provide a strategic interface for health, social care services and Welsh Government HSSG officials. This Group would also provide updates to myself and my office and to the Director General of Health and Social Services and the Director of Social Services, these would be informal and either via email or verbally by the chair Samia Edmonds.

114. As part of the Health and Social Services Covid-19 structure (**FAM2BCMO/22 – INQ000066199**) another group or cell was formed consisting of myself, Jean White, the Chief Nursing Officer for Wales, Albert Heaney, Director of Social Services, Samia Edmonds, Chair of the Covid-19 Planning and Response Group and Andrew Goodall, the Director General of the HSSG and Chief Executive of the NHS in Wales. In terms of structure, this sat between the MHSS and the Covid-19 Planning and Response Group but more than anything it was a regular meeting at which myself and others responsible for key areas in the HSSG could discuss issues with Andrew Goodall as Director General. These meetings covered general updates and sharing of information and agreed implications for the health and social care system. I also had regular separate one to one meetings with Andrew Goodall to keep him up to date with events from a public health perspective but he was also very engaged in meetings with MHSS and FM so had a number of information sources. I do not recall a clear name for this group, but I think some referred to it as the "Director Cell" or "Director group". I am not aware of a note of this, but Andrew Goodall's office may have kept one. If so, I do not recall this being circulated to attendees so was likely for his own reference and record.

NHS Executives meetings

115. To keep abreast of the situation within the NHS I would also regularly attend the Director General's calls with the Chief Executives of the NHS. This was attended by all 7 Local Health Boards, Public Health Wales, Welsh Ambulance Service, Velindre NHS Trust, the NHS Wales Informatics Service[1], the NHS Wales Shared Services Partnership, Welsh Health Specialised Services Committee and the Emergency Ambulance Service Committee. This regular meeting would have a standard agenda which covered a national overview provided either by the Director General or myself, a public health update from Public Health Wales and a discussion between all attendees on any required national action, system risks or organisations updates and assurance. It was used to keep the system informed of developments, to monitor impacts of the pandemic and to share practice on solutions that were being developed.

Core Covid-19 Group

116. There was also a cabinet sub-group, known as the Core Covid-19 Group ("CCG"), established in March 2020 and continued until September 2020. Initially this comprised the First Minister, Minister for Health and Social Services, Minister of Housing and Local Government and Minister of Education. The Deputy Minister of Social Services was also able to attend in place of the Minister for Health and Social Services if demands on his time increased. This was intended to be the core membership but there was an open invitation to other Ministers and membership would be reviewed.

117. The first meeting of the Core Covid Group was held in person in the Cabinet Room in the Senedd Ty Hywel building on the 11 March 2020. I provided an update on the public health situation followed by Rob Orford with a technical briefing and Reg Kilpatrick with a policy update. These meetings were attended by a number of officials who were key to the covid-19 response and the Ministers Special Advisers. Minutes were taken by the Cabinet Secretary. My attendance at these meetings was similar to that of Cabinet in that I was there to provide an update of the current public health situation which helped to inform Ministers decisions. These meetings were scheduled every Wednesday morning with a public health update as a standing item on the agenda.

118. On the 25 March 2020 the Core Covid Group membership was widened to include the Chair of the Welsh Local Government Association ("WLGA") and from the 1 April 2020 the opposition party leaders for Plaid Cymru / Conservative parties in Wales. The

[1] NHS Wales Informatic Service functions has now been replaced by Digital Health and Care Wales.

Chief Executive of the Wales Council for Voluntary Action was invited from the 8 April 2020 and various external groups were invited to provide updates from their respective areas as well, such as the Police, Army and the Black Asian Minority Ethnic advisory group. It became an information sharing forum and the format was for regular updates from the CMO office, the Director General of the NHS and the WLGA. My office would not typically prepare any papers for this meeting but I or a representative from my office would attend to provide an update on the public health situation in Wales. This group ceased after September 2020. I am not sure why this ceased or whether it was replaced or superseded by another group. The group and meetings were organised by the First Ministers office.

Executive Committee

119. On Tuesday 25 February 2020 there was the first Coronavirus Executive Committee ("ExCo") meeting. ExCo is the strategic decision-making forum that supports the Permanent Secretary as Principal Policy Advisor to the First Minister, Principal Accounting Officer and Head of the Welsh Government civil service. From February 2020 a sub-committee of ExCo was formed – ExCovid-19. ExCovid-19 was made up of officials from across the organisation who are involved in dealing with and co-ordinating the Welsh Government's response to Covid-19. The sub-committee was chaired by the Permanent Secretary. ExCovid-19 met weekly and the topics covered would vary from internal resourcing discussions to discussions on key workers or PPE supplies. I would often attend ExCovid meetings and provide an update on the current public health situation, although sometimes other members of the team would represent me, particularly if there were specific topics or "Deep Dives" which they would have a particular interest or expertise in and so it would be more beneficial for them to attend in my place.

Incident management group

120. In March 2020 my office formed an informal incident management team consisting of people from the Welsh Government Health and Social Services Group and the Health Protection team to assist information sharing as part of the Welsh Government's response to the Covid-19 pandemic. This was initially chaired by me but as demands on my time increased this passed to Gill Richardson and my attendance to this group dropped off, ceasing in around September 2020. The group continued to meet throughout 2020 and 2021. I referred to it as an incident management team, but Gill christened it "Silver Team". This was a very informal meeting and touch point for those

working actively on the Covid-19 response involving those with professional lead areas/other roles in CMO(W) office in supporting the health protection team.

121. The membership of this group was not static and was initially chaired by the by myself but as demands of the pandemic increased, I stopped attending but Dr Gillian Richardson in my office continued these on an informal footing.

122. We did not have terms of reference for the group and membership was not logged but typically this included the health professional leads and senior medical officers set out in the attached listed in exhibit **FAM2BCMO/23-INQ000282312.** As different professionals came in they would be invited to the group as well.

Ministerial Sit Rep meetings

123. There was from around mid-April to October 2020 a weekly, usually Monday morning, check-in meeting with the First Minister and Minister for Health and Social Services attended by key officials as well as myself and Rob Orford. This was an a "sit-rep" style meeting and the updates from myself and Rob Orford would inform the First Minister and enable him, along with the Minister for Health and Social Services to set the tone for the priority areas for officials that week or leading up to the 21 day review period. These meetings were not, to my knowledge, minuted and there was no agenda. The format of the meeting tended to be opening with an update on the current public health situation in Wales and then a discussion on what issues had been raised as potentially for review at the 21-day point.

Welsh Government Cabinet meetings

124. The Cabinet, chaired by the First Minister, is the principal decision-making body of the Welsh Government and it was here where key decisions about non-pharmaceutical interventions in Wales were made.

125. Cabinet was meeting frequently during the early weeks and months of pandemic. Whilst all portfolio Ministers brought pandemic related proposals and recommendations to Cabinet for discussion and agreement, the key overarching proposals and recommendations concerning the strategic response to the pandemic, such as restrictions and easement, were presented to Cabinet by the First Minister and the Minister for Health and Social Services.

126. In formulating proposals and recommendations for Cabinet, the First Minister and the Minister for Health and Social Services were supported by a relatively small group of

officials including myself and the Director General for Health and Social Care/Chief Executive NHS Wales, and the Chief Scientific Officer for Health and from around March 2020, the Director for Local Government and Covid-19 Response. A small number of Special Advisers were also involved, this tended to be Clare Jenkins (who was the advisor for the Minister for Health and Social Services) and then Jane Runeckles or Madeline Brindley (who worked with the First Minister) who assisted in signposting any stakeholders who needed to be contacted for views or any wider considerations to take into account.

127. I began attending Cabinet meetings from March 2020 to verbally brief the Cabinet on the latest risk assessment and advice in respect of the virus. Initially, I attended Cabinet on an ad hoc basis but once we got into a regular pattern with the 21 day review process for the Health Protection (Coronavirus) (Wales) Regulations 2020 I would typically attend every three weeks although occasionally officials from my office would attend on my behalf and brief me.

128. In putting together advice for Ministers or making decisions in response to Covid-19 I pulled together various inputs of information and data coming into the CMO(W) office from wider UK sources such as the UK CMOs, the Senior Clinicians Group and the JBC as well as the sources in Wales via TAC, KAS and Public Health Wales. My principal role throughout the pandemic was to present to Ministers a summary of all those various inputs. That summary needed to be based on the most up to date information, succinct and relevant to the issues and recommendations being put by policy officials before the Ministers. In order to produce that summary, I was heavily reliant on the timely input of others and was required to place a high level of trust and faith in the data and work in close collaboration with colleagues such as Rob Orford.

129. My advice to Welsh Ministers would invariably be verbal advice at meetings but this would also at times be accompanied either by a short paragraph included as part of the Ministerial Advice being provided by policy officials or, if the circumstances warranted it, as a separate annex to that Ministerial Advice. Once we got into a regular rhythm with the 21-day process I would usually prepare in advance of Cabinet meetings a CMO Advisory Note alongside TAC briefings/advice which would be incorporated in the Cabinet Paper. My advice notes would inform the Cabinet discussions. Typically, the policy official involved in producing the papers the 21-day process was Tom Smithson although members of his team and the Covid-19 Project team under Reg Kilpatrick would also provide advice. Their names will be on the MAs submitted; I do not recall all of them.

130. From the end of May 2020 that advice was published on the Welsh Government website as part of the announcement on the outcome of the review of the legislation. This was for there to be transparency on the factors that were being considered as part of the decision making. A list of all announcements or public statements by myself is provided in exhibit **FAM2BCMO/24 – INQ000066200.** All Cabinet meetings attended by myself are listed in exhibit **FAM2BCMO/25 – INQ000066201.**

Public health communications

131. During the pandemic my role developed to one where not only was I advocating for the people of Wales on public health matters, but I was communicating frequently with the public and stakeholders, providing updates, advice and guidance on a scale that had never occurred before.

132. From the 24 January 2020 I began issuing public health links, or CMO alerts as they were also often referred to as, to all LHBs and NHS Trusts in Wales, as well as to the NHS Wales Shared Services Partnership (for onward transmission to all GP's, Community Pharmacists, Deputising services; Health Board Chief Pharmacists and Prescribing Advisers and all independent / private clinics, private hospitals and hospices in Wales). These alerts were also copied to NHS Direct Wales; the British Medical Association; the Royal College of GPs; the Royal College of Nursing; the Royal College of Midwives; The Royal Pharmaceutical Society; The Community Pharmacy Wales and The Royal College of Paediatrics and Child Health Wales.

133. This was an established method of cascading important timely information to the NHS in Wales and other key stakeholders. The purpose of the alerts was to inform and reassure the NHS, address pressing concerns and highlight any guidance or key advice. While these are referred to as CMO alerts these would be from the office of the Chief Medical Officer for Wales so not always signed by myself. Alerts could also be issued in collaboration with others such as the other three CMOs, the Chief Nursing Officer for Wales or Chief Pharmaceutical Officer for Wales. A list of all the public health alerts issued by the CMO(W) office for the specified period is provided at exhibit **FAM2BCMO/26–INQ000252575**.

134. On the 31 January 2020 I issued a public statement confirming self-isolation measures for those travelling from China and summarised the co-ordinated action across the four nations. This was the first of many public announcements from the office of the CMO during the pandemic. In addition to regular public announcements,

from March 2020 I also began attending or leading the regular Welsh Government live press conferences entitled 'coronavirus update' which were posted on social media and later, in March, I began a series of correspondence to those people in Wales who were advised to shield from the virus to ensure they were updated on the latest advice.

135. As I set out above, I also provided a more formal report for the public and key organisations serving the people of Wales in the form of my annual reports.

136. In terms of planning or assessing the public health messaging this was not done by myself or my office. Whether any different messaging by UK Government or other devolved governments impacted on the clarity of messaging for Wales would also not be something I could speak to directly. Neither do I consider I am in a position to comment upon whether public confidence was affected by any alleged breaches of rules and standards by the Welsh Ministers, officials or advisors. I believe behavioural management information was commissioned and I do recall that we had discussed concerns, from a health perspective, that 'stay at home' messaging could have a negative impact on those who needed medical treatment. I was not however involved in the commission of any advice on this.

4. Decision making by the Welsh Government relating to the imposition or non-imposition of NPIs

137. On Friday 28 February 2020 the first Welsh patient was confirmed as testing positive for Covid-19. I learned about the first Welsh Patient via a text message from Public Health Wales. I do not recall who sent the message and no longer have access to it. I immediately called the Director General of the HSSG, Andrew Goodall to ensure he was aware of the situation.

138. At the end of February 2020, UK CMOs assessed the risk to the UK as moderate noting that the following scenarios would trigger a reassessment of the UK response:

    i. Sustained transmission in Europe or other countries where UK has close ties

    ii. Clear failure of Chinese measures to reduce spread.

139. We knew that coronaviruses were a large family of viruses with some causing less-severe disease, such as the common cold, and others more severe disease such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). Although the epidemiology of the new coronavirus was still being

assessed data to date suggested that approximately 20% of confirmed cases result in severe illness and the mortality rate was much less than that for MERS and SARS.

140. As we moved into March, we started getting increased questions about major events and mass gatherings as concerns about the rates in Wales grew. We did not have a formal mechanism in place at that time for myself or my office to be consulted in relation decisions on NPIs, but I was copied into email correspondence relation to Scotland vs Wales 'Six Nations' rugby match on 11 March 2020. The CSAH provided written advice to the effect that the size of a gathering is not as much a factor for transmissibility, as time of contact and nature of activity. The advice at that time was that on balance people attending events where they remained fairly static would probably carry less risk than if people chose to watch the game in city centre pubs where people were likely to move from one to another. A copy of the advice from the Technical Advisory Cell is exhibited in **FAM2CMO/27-INQ000271443.** I have very little recollection of the discussion, but I did speak to the Welsh Rugby Union at the ministers request. The information I would have provided would have been consistent with the Technical Advisory Cell advice exhibited above. I do not believe I have any notes of this discussion. The same advice would have applied to the Stereophonics Concerts in Cardiff on 14 and 15 March 2020 but I do not recall any discussion regarding this.

141. The moderate assessment changed to high on 12 March 2020 and people with symptoms such as a high temperature and a new continuous cough were told to self-isolate for 7 days and avoid all but essential contact with others. The UK Government press release noted that the UK Chief Medical Officers raised the risk to the UK from moderate to high. I do not recall how this decision was communicated to Ministers in Wales but at this point I was meeting with the First Minister and Minister for Health and Social Services daily so it would be likely that I provided a verbal update to Ministers.

142. On the 16 March 2020, Wales had its first Covid-19 death and the UK Government, in conjunction with the Welsh Government, announced significant changes to government approach to social distancing and advice to vulnerable groups. People with symptoms should self-isolate for 7 days, those in households with symptoms should isolate for 14 days, and the public should avoid all but essential travel and contact with others. In addition, people aged over 70 and those with major underlying health conditions should self-isolate for 12 weeks from Saturday.

143. Given the situation a statement was made on 17 March 2020 by Vaughan Gething, the MHSS confirming that the incidence or transmission of novel Coronavirus constituted a serious and imminent threat to public health. This statement was made for the purpose of putting in place the measures outlined in the Health Protection (Coronavirus) (Wales) Regulations 2020 which were considered an effective means of delaying or preventing further transmission of the virus in Wales and which came into force on the 18 March 2020. These regulations were made under Part 2A of the Public Health (Control of Disease) Act 1984 ("the 1984 Act") and as such could only put in place restrictions which were "*for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination"*. The Regulations could only impose restrictions "*in the event of, or in response to, a threat to public health*" and any restriction imposed by the Regulations had to be "*proportionate to what is sought to be achieved by imposing it*". This declaration of a serious and imminent threat was based on my advice which was incorporated in policy officials' advice to the MHSS on the 17 March 2020 on the necessity of making the regulations. A copy of this advice is exhibited in **FAM2BCMO/28-INQ000097673**. My advice was based on the increasing number of cases in Wales, the declaration by the World Health Organisation declaring a pandemic and the position in Italy at the time. This declaration remained in place for the duration of the pandemic period being reviewed each time subsequent regulations were made under Part 2A of the 1984 Act and at each 21-day review period considering the public health rationale for maintaining the restrictions in Wales.

144. On the 18 March 2020 I attended the Senedd's Health, Social Care and Sport Committee with Rob Orford to provide a briefing on the current public health situation. At this point, we had 136 cases identified as positive with coronavirus in Wales, and, very sadly, we had two patients who had died with coronavirus in that last week. I explained that we had moved from the approach set out in the four nations Coronavirus Action Plan of trying to contain the epidemic here in the UK to one of delaying its impact. Essentially, we were trying to buy time so that the NHS and our public sector had time to prepare for the anticipated significant increase in the number of cases coming forward.

145. It was shortly after this Committee meeting, on the 23 March 2020 that a national lockdown was implemented in all four nations. Prior to 23 March the consensus view from SAGE and among the UK CMOs (based on disease modelling) was that a complete lockdown could have an adverse effect in that it would lead to a very large

viral resurgence in the autumn/winter of 2020. In terms of the four CMOs I do not recall there being any disagreement on that position. I cannot comment on SAGE as I did not attend this. As it became apparent that Northern Italy was at the point of health service collapse the decision was taken to lockdown from 23 March 2020. I was not consulted on the UK national lockdown and I do not recall a CMO discussion or formal change in our advice which led to this decision. This was a decision by ministers at COBR led, I understand, by the UK Government. The reality was that people were dying, we were looking at what was happening in Europe and in particularly in Italy at that time and had no choice but to act on the modelling that was being presented.

146. The Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 ("the Regulations") were made on 26 March 2020 replacing the regulations made on the 17 March 2020[2]. Regulations were also made under Part 2A of the 1984 Act and as such the legal requirement for any restrictions to have a public health purpose and also the need to consider the impact of the restrictions on public health meant that I was advising Ministers on these matters (in conjunction with colleagues such as Rob Orford, the Chief Scientific Advisor) before they took decisions to implement or amend the restrictions.

147. The Regulations came into force on 26 March 2020 and required a review every 21 days. In broad terms my advice was based on an assessment of how any amendments to the restrictions would impact on the four harms of the pandemic which had been articulated by Chris Witty, the CMO for the UK. The four harms were as follows:

    i. direct harm to individuals from SARS-CoV2 infection and complications including for those who develop severe disease and in some cases sadly die as a result;

    ii. indirect harm caused to individuals if services including the NHS became overwhelmed due to any sudden large spike in demand from patients with Covid-19 on hospitals, critical care facilities and other key services;

    iii. harms from non-Covid illness, for example if individuals do not seek medical attention for their illness early and their condition worsens, or more broadly from the necessary changes in NHS service delivery made during the pandemic in Wales to pause non-essential activity; and

[2] Regulations revoked by Schedule 21 paragraph 68 of the Coronavirus Act 2020 (c. 7)

iv. socioeconomic and other societal harms such as the economic impact on certain socioeconomic groups of not being able to work, impacts on businesses of being closed or facing falling customer demand, psychological harms to the public of social distancing and many others.

148. A fifth harm was added to the list formally in Wales: (v) the way Covid-19 has exacerbated existing or introduced new inequalities in our society. The Welsh Technical Advisory Cell for COVID-19 added this formally as a 'fifth harm' from July 2021 as outlined in the TAG paper exhibited in **FAM2BCMO/29- INQ000239550.** I considered all five harms when providing my advice to the Ministers.

149. At no time did I consider or become aware of others considering herd immunity as a potential means of responding to the pandemic. As the pandemic progressed, the availability of vaccines and different variants of the virus also informed my view. As I have set out in detail above, my advice was based on a variety of sources including information from SAGE (via TAC), KAS, Public Health Wales and my CMO colleagues.

150. Before turning to the specific advice, I would like to make clear that these were difficult decisions and it was clear to me and those around me that there was no perfect solution or constantly right approach to the public health dangers that the pandemic presented. As best we could, we were trying to balance the direct harms of the pandemic against the other harms.

151. I set out below my advice in respect of NPIs in the following broad time frames.

i. **Lockdown**: March – June 2020;

ii. **Gradual easing of restrictions**: June – September 2020;

iii. **Increase in NPIs**: September – 26 October 2020;

iv. **Firebreak**: 26 October 2020 – 9 November 2020;

v. **Restrictions short of lockdown** – 9 November 2020 – 4 December 2020;

vi. **Attempt to safeguard Christmas mixing**: 4 December – 19 December 2020;

vii. **Lockdown**: 19 December 2020 – mid-March 2021;

viii. **Gradual easing of restrictions**: mid – March 2021 – September 2021;

ix. **Increasing concern**: October 2021 – December 2021;

x. **Restrictions to no more regulations**: Post Christmas 2021 - May 2022

152. In addition to providing advice directly to Ministers verbally in meetings or in Cabinet (as set out in detail below), I would also receive ad hoc requests for public health advice from Welsh Government policy officials to assist with developing guidance, advising external stakeholders or for lines to be incorporated into formal Ministerial Advice ("MA") submitted by policy officials to Ministers. Depending on the topic and nature of the request I would either respond to these directly myself or at other times I may have delegated responding to members of my team or to the DCMO, Dr Chris Jones.

153. Ad hoc requests came to me via email, Teams chat or telephone). A record of ad hoc advice requests have not been retained by my office. As noted often it would be requests to comment on lines or guidance and not all would be dealt with my myself.

154. The information below has been prepared following a review of the relevant Cabinet minutes and papers as well as advice prepared by officials on the Ministerial Advice template form.

155. I have not undertaken an analysis of decisions which diverged from the UK so have limited any comments on divergence to information I was aware of at the time due to my role as CMO. An area of difference in my experience was in relation to face coverings on which I directly provided advice, which is summarised above in paragraph 83.

156. Generally, my advice was for a four nations approach but there were areas or situations where a more local targeted approach was required. In terms of discussion with the other nations, this would be after the decision had been taken by the minister unless at his request I was asked to bring in policy or stakeholder views. The main factor in assessing whether to take a different approach was, from my perspective, the state of the epidemiology in Wales or parts of Wales and how, applying the hierarchy of controls, we could eliminate or minimise the risk of transmission. Understanding the impact of NPIs was significant to be able to consider NPIs in context.

Lockdown – March – June 2020

157. As set out above, I advised in March 2020 that the public health threat from Covid-19 was "serious and imminent" for the purposes of using certain powers under Part 2A of the Public Health (Control of Disease) Act 1984 as a means of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination.

158. At the first 21-day review on 16 April 2020 I advised that from a public health perspective the restrictions should remain in place. My advice was as follows:

"*At this point in time, the view of the UK Scientific Advisory Group for Emergencies, that the restrictions and requirements has almost certainly lowered the reproduction number of COVID-19.*

The lifting of the current restrictions and requirements in an unplanned way and prior to a fuller understanding of community transmission would almost certainly lead to a resurgence of the community transmission of COVID-19, an increase in demand on NHS services and an increase in deaths".

159. This advice was followed and no substantive changes to the restrictions were made. At this point, the virus had not been sufficiently suppressed and the Welsh NHS remained under serious threat.

160. At the next 21-day review on 7 May 2020 I advised that based on evidence from SAGE and TAC that in terms of direct harm from the virus, the key indicators suggested that transmission was stable or stabilising but that too fast easement would lead to exponential growth. I informed Ministers that I was concerned about indirect harms, especially for the young and for socially disadvantaged groups and I suggested that we needed more information on the nature of the indirect harm to these groups to for future reviews. I recommended that the Welsh Government get contact tracing up and running. I advised that the limited easements suggested should be followed. I recommended against the use of mandatory face masks.

161. At the third 21-day review on 27 May 2020 the proposal was that the Regulations should be amended to change the stay-at-home provisions to a 'stay local' message to allow for outdoor activity. I indicated that I supported the set of easements that had been proposed as they were unlikely to lead to significant increase in the community transmission of the virus and it was important to allow people some respite over the summer months, particularly as there may be a need to re-impose more restrictive measures in the winter if viral activity increased. This move to a stay local message

marked the end of the strictest form of lockdown and mitigated some of the indirect harm caused by people not being able to be outside and take exercise.

Gradual easing of restrictions: June – September 2020

162. I was not able to be present for the fourth 21-day review on 17 June 2020 but the DCMO, Dr Chris Jones, attended on my behalf.

163. I gave an update to Cabinet on the public health position in Wales for the fifth 21-day review on 7 July 2020. The First Minister asked whether there was headroom to further relax the restrictions. I set out that in broad terms, the situation was stable and improving and that as a consequence there was some headroom to release some of the restrictions but that each sector would need to take guidance into account. My advice dated 30 June 2020 made clear that I remained conscious of the need to enable friends and families to reconnect in a cautious and stepwise manner. My view was that the proposals for extended households which were being discussed at this review were an acceptable means of allowing the reconnection of families and supporting childcare needs. I recommended that clear guidance was given to the public about the need for record keeping and maintaining exclusivity with one other household.

164. At the sixth 21-day review on 28 July 2020 the Cabinet had been provided with key data from TAC which demonstrated that the circumstances were favourable to continue to ease some of the restrictions. However, I set out that there was a need to monitor the situation as there had been an increase in cases in the Wrexham area.

165. At the seventh 21-day review on 18 August 2020 the First Minster invited me to provide an update on virus transmission rates and whether there was headroom to further relax the restrictions. The First Minister indicated that the planned reopening of schools in September would be the priority for available headroom which would place constraints on the ability to relax further measures. I indicated that there was some headroom for further controlled easing in addition to preparing for schools to reopen but that we needed to be mindful of what was happening elsewhere in the UK (there were increases in cases in England, Scotland and Northern Ireland). Rob Orford and I had not recommended the proposal to allow any two households to meet indoors subject to social distancing. Ministers decided that the proposal should not be included in the current easing of restrictions. I indicated that while meeting indoors presented a higher risk of transmission than meeting outdoors, I did not object in

principle to such proposals providing the necessary precautions were taken and the venues were well ventilated. I did state that clear parameters needed to be set and there should be guidance and additional mitigation measures in some settings, such as requiring visitors to have a negative test before entering care homes.

Increase in NPIs: September – 26 October 2020

166. The eighth 21-day review was conducted in Cabinet on 8 September 2020. The First Minister invited me to provide an update on virus transmission rates and whether there was headroom to further relax the restrictions. I said that I was concerned about the alarming increase in cases in Wales and across the UK. I explained that over the previous 4 days the number of infections in Wales had tripled to 150 cases since May. Caerphilly county had accounted for almost a third of the increase which had led to the imposition of a local lockdown. I felt that the situation was taking a turn for the worse and that there was a need to be more precautionary with any further lifting of restrictions. The Cabinet agreed that given the emerging situation and my concerns, the restrictions on households meeting with other households in the home should remain in force following the current review period. It was also decided that the definition of 'a gathering' should be tightened.

167. There were two further Cabinet meetings on 21 and 28 September 2020 that I was unable to attend. Chrishan Kamalan, Acting Deputy Director for Covid-19, attended on my behalf. I can see from the Cabinet minutes on 21 September that urgent action had been needed to combat the spread of the virus in four more local areas in Wales by this point. The First Minister referred to the fact that there was a COBR meeting the next day when all four Governments would be able to share experiences of responding to recent increase in cases.

168. On 1 October 2020 I attended Cabinet as part of the 9th 21-day review of the Regulations. I set out that there had been a significant increase in new cases since the last review of the Regulations with 398 cases being reported the previous day. University towns were hotspots. Given the increase in cases and the introduction of Local Health Protection Areas, designed to limit the spread of infection within Wales, specifically from areas of high prevalence to areas of lower prevalence, there was very little scope to relax any further measures.

169. I attended Cabinet on 15 October 2020. The meeting had been called because the First Minister was seeking the agreement of the Cabinet to apply a circuit breaker to

the whole of Wales to reduce the significant increase in transmission of the virus. At this point, and for some time afterwards, the terms firebreak and circuit breaker were used interchangeably. In this statement, I will refer to a firebreak. I set out my view which reflected that of Sir Patrick Vallance in COBR that the UK government's proposal for a 3 tier system would not stop the rapid spread of the virus and a firebreak was the preferred option. Informed by advice I had received from Public Health Wales, I explained that at least 2 weeks was needed but that 3 weeks was preferable although there was a need to consider the economic, financial and social impact of a longer firebreak. Cabinet agreed in principle to a firebreak starting on 23 October 2020 and covering 3 weekends.

170. Cabinet considered the 10th 21-day review on 18 October 2020. The First Minister explained that a substantive decision on applying a firebreak to the whole of Wales was needed following the agreement in principle on 15 October. I set out that the TAC conclusions were clear that, without intervention, the continued increase of cases of Covid-19 in Wales, in hospitals and in Intensive Care Units ("ICUs") would be too high for the NHS to sustain. TAC recommended a 2/3 week hard firebreak from Friday 23 October - Monday 9 November. I submitted a written advice on the firebreak on 19 October 2020 which made clear the need for it. I also stated: "*I am acutely aware of the indirect harms which will result from the proposed restrictions. Our Chief Economic Adviser estimates that over £400 million of output (GDP) and the associated income could be lost, before taking account of supply chain effects. Payments under the UK government job support schemes will not fully offset this lost output and income. The adverse economic and social effects are likely to last beyond the period of the circuit-break, worsening labour market prospects for those who lose employment or who have entered the labour market in the recent past. Evidence from previous recessions suggests that young people who enter the labour market in such circumstances suffer long term adverse consequences, affecting economic outcomes, health and well-being, and have an increased risk of premature mortality. These, and other, effects will tend to exacerbate socio-economic inequalities. However, the indirect harms could be much greater if the proposed circuit-break was not introduced, the NHS becomes overwhelmed, and a longer or more stringent national lockdown is subsequently judged to be necessary*".

171. There was a further Cabinet meeting about the firebreak on 19 October 2020. I was invited to give my view on the current situation. I set out that for the first time during the second wave of infections the incidence for Wales was measuring higher than 100

cases per 100,000 people. It was of particular concern that the rate of infection within the over 60s was 80 cases per 100,000. The TAC advice was clear that a comprehensive fire break was needed to prevent an exponential rise in cases. The Cabinet also referred to advice from me and TAC that secondary schools would only open after half term for pupils in Years 7 and 8 (childcare settings and primary schools should reopen as normal after half term).

Firebreak: 26 October 2020 – 9 November 2020

172. At a Cabinet meeting on 29 October 2020 the Cabinet wished to discuss options for the period after the firebreak. I informed them that the situation was worsening in Wales. The firebreak should make a difference but it would take a while to know what the impact had been. My view was that it was too early to take a view on what should be in place after the firebreak.

Restrictions short of lockdown – 9 November 2020 – 4 December 2020

173. At the Cabinet meeting on 16 November 2020 the First Minister invited me to provide my views on the spread of the virus. I advised that the firebreak had interrupted transmission and R rate was now at 0.8. Hospitals were reporting trends of stabilisation and reduction. I stated that I was concerned that with the end of the firebreak there would be a rise in cases in early December. I advised that there was a need for a communications campaign around behaviour.

174. There were two Cabinet meetings on 26 November 2020. The Cabinet was being asked to consider whether to impose further restrictions immediately in order to ensure that families could meet for up to five days at Christmas. I set out that the benefits of firebreak now largely lost. The R rate was at 1.4 and there was a significant growth in the prevalence of the virus. The Cabinet was referred to a SAGE paper on the different approaches in different nations and how effective they had been. The verdict on Wales was mixed. In England, tier 3 measures had been effective. The Cabinet agreed to an all Wales approach to restrictions in the lead up to Christmas.

175. I attended a Cabinet meeting on 29 November 2020 the purpose of which was to consider the restrictions that would be put in place from 4 December 2020. I was asked to outline the current epidemiological trend. I advised that unfortunately the number of cases was on an upward trend with hospitality being a factor especially given the increase in social mixing which relates to alcohol consumption.

Imposition of restrictions - attempt to safeguard Christmas mixing: 4 December – 19 December 2020

176. At the Cabinet meeting on 9 December 2020, it was clear that further restrictions would need to be put in place after Christmas. When I was invited to give an overview of transmission rates, I informed the Cabinet that cases were rising fast and the number of infections was far higher in Wales than it was in England and Scotland. Wales would need to go into level 4 restrictions by 28 December.

177. There was a further Cabinet meeting on 10 December 2020 to confirm arrangements for 28 December if infection rates did not improve. I advised that secondary schools should move to online learning from 14 December 2020 as infection rates were by this point 370/100,000. I submitted the advice that I had received from Public Health Wales to the meeting which advised urgent additional measures. I advised the Ministers to consider further national restrictions in line with the Public Health Wales advice.

Lockdown: 19 December 2020 – mid-March 2021

178. On 4 January 2021, following advice from the JBC my CMO colleagues and I issued advice that the risk level should be raised to the highest possible level – UK Alert Level 5. In response there were strengthened lockdown measures across mainland Scotland and the whole of England went into full lockdown. In Wales, where the Alert level had already been raised to the highest level this led to schools being instructed to close.

179. I attended Cabinet on 6 January 2021 for the 21-day review and was asked by the First Minister to provide the latest advice on the transmission of the virus and the impact on the NHS. I advised that cases were very high in most parts of Wales and that the 7-day average was around 470 in every 100,000. There had been rapid increases in north-east Wales. I noted that the data for infection rates during the new year period were unclear due to reporting issues and the reduction in testing over public holidays, but it was hoped that information on the impact of the Alert Level 4 restrictions in Wales would be available by the end of the following week. I set out that even with restrictions the new strain appeared to be driving an increase in cases across the whole of the UK. The Cabinet was informed that the NHS in Wales was in a very challenging position as the number of people admitted to hospital had continued to rise for the past 2 weeks. Cabinet agreed that the Alert Level 4

restrictions should be maintained across Wales for a further 3 weeks and that there should be further tightening of restrictions, in particular the Regulations should be changed to make it explicit that showrooms were classed as non-essential retail and should close. The Chief Scientific Adviser for Health was asked to provide a report on the new variant and its impact on transmission in schools.

180. At the Cabinet meeting on 25 January 2021, I was asked to update Ministers on the transmission of the virus and the impact on the NHS. I set out that community transmission rates had fallen since 8 January 2021 but that there remained concerns about the new variant which could be up to 70% more transmissible (this was still being researched). On the positive side, vaccine coverage was steadily increasing. Ministers decided that as indicators remained high across Wales and the NHS remained under strain Alert Level 4 should be maintained until the next review on 18 February 2021.

181. There were Cabinet meetings on 16 and 17 February 2021 which I attended. Ffion Thomas also attended from my office and my DCMO, Dr Chris Jones, attended on 17 February 2021. I advised that the situation across Wales was improving, and the R rate was below 1. Over 780,000 people in Wales had at this point had a first dose of the vaccine. I did strike a note of caution as the SPI-O-M had advised a slower easing of restrictions as the new variants (the Kent variant was mentioned in the advice to Ministers) had injected a degree of uncertainty. There was also uncertainty about the effect of vaccines on transmission and the degree of vulnerability in the population even when vaccinated. I advised that to allow the surveillance data on schools to be analysed sufficiently only low risk options should be considered for any amendments.

182. Cabinet agreed that Wales should stay at Alert Level 4 but indicated that they were hopeful that by the next review they would be able to move away from the stay-at-home restrictions. The meeting on 17 February 2021 focused on the move out of lockdown and a potential unlocking sequence, noting the cautious approach advocated by SAGE and TAC.

183. At the Cabinet meetings on 8 and 9 March 2021 the First Minister asked Ministers to agree a package of easements for the 11 March review. At this point the indicators in Wales were continuing to improve and had reached the levels where the WHO was advising a gradual easing. There was a proposal for a package of easement measures around getting children back to school and encouraging people to exercise outside. Cabinet agreed that from 15 March 2021 all primary school children should

return to school and those in years 11 and 13. From 13 March 2021 the stay-at-home requirement would change to a stay local and same guidance that was in place in June 2020 would be in place. On 9 March Cabinet returned to discuss what easements could be made. I advised that given the complications of the new variant, a staggered approach to the lifting of restrictions would allow better monitoring of the impact on the spread of the virus on the specific easements. Allowing too many easement measures at the same time could create a rapid increase in infection without being able to distinguish between measures and identify the specific risk.

Gradual easing of restrictions: mid – March 2021 – September 2021

184. I attended the Cabinet meetings on 29 and 31 March 2021. My advice at this point was that I continued to support the incremental and cautious approach to the relaxation of restrictions starting with those that return children to face to face education, that offer benefits to health and wellbeing and those that pose minimum risk to public health. I advised that the epidemiological picture remained conducive to reopening non-essential retail and close contact services with mechanisms in place to test and trace and contain local outbreaks. I recommended ongoing and careful monitoring of the relaxations.

185. Cabinet agreed the measures, but Ministers expressed concern that the timing of the cycle of easements for 22 April which was after England meant people might travel across the border for hospitality and fitness. The Cabinet agreed that it was important to follow the public health advice and requested advice from officials on the effect of moving forward the easements scheduled for 22 April by a week. On 31 March 2021 the Cabinet was informed that the advice from the public health officials was that one week was not enough to see the effect of the easing of restrictions on 12 April 2021. Cabinet indicated that the First Minister should set out the list of easements on 26 April 2021 and 10 May 2021 and noted that my advice should be published at the same time as the press conference.

186. At the Cabinet meeting on 19 April 2021, I advised that in general terms, the situation was stable, and Wales had the lowest case rates overall in the UK. Based on this the Cabinet discussed a relaxations package for 26 March with a move to Alert Level 3 in Wales from 3 May.

187. On 10 and 12 May 2021 I attended Cabinet with Chris Jones (DCMO) and NR NR from my private office. I advised that case rates were gradually

decreasing, and the situation was relatively benign. Public health conditions did support a move to Alert level 2 on 17 May 2021 but there were a number of factors for the Ministers to consider. My view at this point was that an easement of restrictions was a proportionate response to the relative risk to public health but that we needed to maintain a level of NPIs and a degree of risk literacy amongst the public in Wales was necessary. On 12 May 2021 changes to social distancing rules were under consideration given announcements by the UK Government and the Scottish government. I outlined some emerging concerns about the rapid spread of what at that point was being described as the 'Indian' variant in London and some parts of the northwest near the border with Wales. I described it as being more transmissible than the Kent variant. The Chief Scientific Adviser for Health and I agreed to provide Cabinet with a note on the spread of the 'Indian' variant.

188. At the point I attended Cabinet on 17 May 2022 the situation remained broadly favourable in Wales. At this point there were 26 cases of new 'Indian' variant cases in Wales.

189. I attended Cabinet on 27 May 2021, advising that in general terms the overall situation remained favourable to easements. I noted that there were still some concerns about the 'Indian' variant, by now renamed the 'delta' variant. At this point there were 59 cases confirmed in Wales. I considered that the two most important risks were the lifting of non-essential international travel and lifting of NPIs such as social distancing and wearing of face masks. There was an acknowledgement of the burden of the restrictions especially on those on lower wages, young people and low skilled and disabled people, those with poor health and the Black, Asian and minority ethnic communities.

190. I was not able to attend Cabinet on 3 June 2021, but Chris Jones (DCMO) attended.

191. I attended Cabinet on 7 June 2021 with Gemma Nye from my private office. There was some discussion of lifting restrictions beyond Alert level one.

192. Gemma and I also attended Cabinet on 16 June 2021. This was an interim review of the restrictions to consider whether any amendments were needed in light of the delta variant. Cases had been rising exponentially in Wales over the previous 2 weeks. Infections were more prevalent in younger age groups, and it appeared that individuals who had had two doses of vaccine were better protected than those who had only received one dose. My advice was that a slower easing would allow more

people to take up second dose of the vaccine. Cabinet agreed to delay the move to Alert level 1 until at least the next review on 15 July 2021.

193. I attended Cabinet on 12 and 14 July 2021 and advised that the current epidemiological picture changed the balance between direct and indirect harms and made it increasingly difficult to justify the stringent use of public health powers to continue restricting economic, social and cultural activities. It had become increasingly clear at this point that vaccination had weakened the link between infection and serious illness and death. As a result, a decision was taken that people who had had two doses of the vaccine would no longer needed to isolate when in contact with a confirmed Covid-19 case. This meant that I needed to write to the clinically vulnerable to let them know the implications of this change.

194. I was not able to attend Cabinet on 29 July 2021, but I am aware that Chris Jones attended and advised that cases had increased rapidly since the beginning of June following a 6-month period of sustained reduction in cases (an 800% increase from a very low base). Deaths remained much lower than in previous waves. I attended on 2 August 2021 and advised that the rate of infection was stable and local were reporting that the position was improving, possibly because the school holidays were creating a natural firebreak.

195. Chris Jones and I both attended Cabinet on 23 August 2021. The First Minister presented a paper which recommended that Wales remain at Alert level 0 for the current review period. I advised that community transmission rates continued to rise and were expected to rise further once school back and hospital and ICU admissions were increasing slowly but were still relatively stable.

196. I attended Cabinet on 13 September having written an advice dated 10 September which set out that although Wales had seen a steady increase in cases, it was not seeing the direct harms that were seen in the first two waves due to the success of the vaccination programme. I did, however, advise that the situation remained serious with daily admissions to hospital increasing at a time when there were other pressures on the NHS. I set out that it was going to be a difficult autumn/winter. It was also becoming clear that the vaccine immunity of some was waning and I advised an immediate booster campaign in line with the Joint Committee on Vaccination and Immunisation ("JCVI") advice. It was also becoming clearer that vaccines had more of an effect on severe disease than they did on transmission. In other words, vaccines were preventing people from the most serious consequences of the disease, but they

were not as successful as preventing people from being infected in the first place. This was significant because it meant that even with high vaccination rates there were still people who had not been vaccinated who remained vulnerable from increased transmission of the virus.

197. Cabinet agreed that Alert level 0 should remain in place for this review period. I updated the Cabinet that my CMO colleagues and I had submitted advice to the UK Government that healthy 12 - 15-year-olds should receive one dose of the vaccine to reduce disruption to education. This impact on education had tipped the balance in favour of vaccination over previous JCVI advice.

Increasing concern: October 2021 – December 2021

198. I was not able to attend Cabinet on 4 October 2021 but the DCMO, Chris Jones attended in my place. At that time Wales had the highest infection rate of the four nations.

199. On 25 and 28 October 2021 I attended Cabinet. Wales had continued to have the highest infection rate in the UK at this point and infections were increasing in the over 60s. Ministers agreed to staying at Alert level 0 but asked how mitigations could be strengthened to avoid moving to Covid-19 Urgent. In my advice to Cabinet, I indicated that it might be necessary to move to Alert level 1 which could require the reintroduction of the need for household contacts of those who tested positive for Covid-19 to isolate.

200. At Cabinet on 15 November attended by DCMO, Chris Jones, Covid-19 cases had fallen and situation in the NHS had stabilised. The objective remained to maintain cases at manageable levels and balance the five harms. Alert level 0 was maintained as case numbers were falling. This accords with the CMO advice drafted for this review which recommended remaining at Alert level 0 whilst supporting self-isolation and encouraging vaccination.

201. On 29 November I was asked by the First Minister to provide an update on Omicron. I advised that it had increased transmissibility over delta and a higher possibility of reinfecting those who had already had Covid-19. It was not yet known if more harmful. The Cabinet agreed to strengthen the use of face coverings in schools.

202. There were Cabinet meetings on 2, 6, 8 and 9 December as concerns about the Omicron variant increased. On 2 December I advised that there were no recorded

Omicron cases in Wales and cases of the delta variant were plateauing. By 6 December I reported that Omicron was spreading rapidly and that there were now four reported cases in Wales. By 8 December 2021 it was likely that the UK Government would implement 'Covid-19 Plan B' in England which involved people working from home where possible and vaccine passport for some venues. I stated that Omicron appeared to have the ability to escape vaccines, but it was not known how severe symptoms would be. On 9 December it was confirmed that England was moving to Covid-19 Plan B.

203. On 16 December 2021 when asked to advise on the current situation I said that the delta wave was stable but that cases of Omicron were increasing. The indications were that the disease from Omicron was much less severe but if numbers were high then it would still put pressure on the NHS. My advice recommended the reintroduction of measures. The Cabinet agreed more stringent measures after Christmas.

204. On 20 December 2021 Cabinet indicated all events indoor and outdoor would be closed to spectators from 26 December 2021. On 21 December a number of Alert level 2 measures were put in place including the rule of 6, meaning that groups of no more than 6 would be able to meet in regulated premises (such as hospitality, cinemas and theatres).

Restrictions to no more regulations: Post Christmas 2021 – May 2022

205. There was a Cabinet meeting on 10 January 2022. I advised the Cabinet that there was still a difficult situation in Wales with significant community transmission. The seven-day average had dipped below 2,000 per 100,000, down from 2,300 per 100,000 the previous week and cases in the over 60s had also reduced. It was too early to tell whether the trajectory had been reversed and the numbers would be influenced by changes to the testing regime, children going back to school and people being required to attend the workplace. I set out that we were waiting for further information on how harmful the Omicron variant was. The Cabinet also received advice from the Chief Scientific Advisor for Health and the Director General for HSSG/Chief Executive of the NHS. Pressure on the NHS was expected to continue throughout January.

206. At the Cabinet meeting on 13 January 2022, Ministers were being asked to consider whether any immediate changes to the restrictions should be made. I advised that the

situation had changed rapidly in the last 48 hours with a reduction in the numbers of cases being reported. At the point of the meeting, it was not clear whether that was because of the change in testing regime or people changing their behaviour over the Christmas period but as the minute records, I considered that there was some optimism that the current trajectory was in decline. It was also becoming clearer that the rate of harm caused by Omicron was less serious for people who were vaccinated. Wastewater data and data from the ONS Covid-19 survey also suggested that infection rates were plateauing. This all fed into the expectation that the Omicron peak had either already happened or would happen very soon. Against this background, I advised that there was headroom to begin to or at least to signal the intention to start relaxing measures. The proposal was to lift some restrictions on 21 January and on 28 January to return to Alert level 0 baseline measures.

207. Given the fast-moving nature of the Omicron wave, there was a further weekly review of the restrictions in the regulations due on 20 January 2022. I attended a Cabinet meeting on 17 January 2022 to outline my advice which was made available to Ministers in advance. It recommended keeping restrictions on indoor mixing but said that there could be limited easements on outdoor mixing. This meeting confirmed the easements on 21 January (outdoor mixing) and the return to Alert Level 0 from 28 January as long as the public health situation remained favourable. There was a return to 21-day reviews with the next review due on 10 February 2022.

208. I was not able to attend the Cabinet meeting on 24 January 2022 but my DCMO, Chris Jones attended on behalf of the CMO office.

209. On 7 February 2022 I attended the Cabinet meeting for the 3-week review of the Regulations. My advice was provided to the Cabinet in advance of the meeting. There was still a high level of community transmission, but the vaccination programme and the lower severity of Omicron meant that the harms were less than the original modelling suggested. I recommended a gradual easing including the removal of the requirement to wear face coverings in optional indoor public places but retaining the requirement to wear them in mandatory settings such as public transport, retail, health and social care. I suggested the voluntary use of the Covid-19 pass. I also recommended keeping legislation and financial support for positive cases who needed to isolate. I considered that isolation for positive cases remained an important and proportionate public health measure to protect others and prevent the spread of Covid-19. I also emphasised that it was important to continue work across the four

nations to develop effective domestic and international surveillance of variants and be mindful that there could be a late flu season which would put stress on the NHS.

210. There was a Cabinet meeting on 28 February 2022 which I attended in advance of the First Minister being required to take a decision about whether to amend the regulations by 3 March 2022. I had provided written advice in advance to inform the decision. In that advice I said that community transmission of virus was continuing at a high but reducing level and it appeared that the Omicron driven wave of infection was receding. Direct harms from the pandemic were continuing but at a much-reduced level compared with previous waves. I advised that it was therefore appropriate to continue our approach of cautious easing of the protections which are still in place. I did ask the Cabinet to note the SAGE and the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG") view that future variants were highly likely to appear and may lead to more significant levels of direct harm than have been seen with the Omicron variant. As I had set out in previous advice, it appeared to me that as we cautiously eased protective measures it would be wise to retain sufficient testing capacity to support individuals who become ill, to protect vulnerable individuals and settings and to ensure that we had an effective system for surveillance and response with regard to new and emerging variants in place.

211. I attended a Cabinet meeting on 21 March 2022 which was intended to consider whether the restrictions could remain in place for the 21-day review which was due on 24 March 2022, but it was not possible to advise on the public health situation at that point as more evidence was needed. Case rates were rising, particularly in those aged over 60 which was a cause for concern and pressures on hospitals and ICUs were increasing. Swansea university had produced some new modelling which needed to be considered and there appeared to be a new sub variant of Omicron.

212. By the Cabinet meeting on 24 March 2022 there was some more evidence, but the situation was still changing rapidly. My advice was contained in the Ministerial Advice on this occasion. I advised that the decision to remove or retain the three remaining protections was finely balanced but that I was in favour of retaining them for a further 3-week period. My view was that the current wave would wane over the next 3-4 weeks but that the high community transmission posed two significant threats: firstly, to the operational delivery of NHS services and secondly to the unquantifiable risks of long Covid-19. I noted that Wales had always been more cautious in release of protections than other UK nations and that the Welsh public had been generally supportive of this approach. My advice acknowledged that the residual protections

were likely to have only a small effect on community transmission but in terms of messaging to the public it would seem inappropriate to remove them at a time when transmission was at the highest level we have seen during the pandemic and harms, although more limited than in previous waves, continue to accrue. It did not appear that the social and economic costs of retaining the remaining protections was large. I set out that if ministers were minded to remove some but not all the protections then I would recommend the retention of the legal duty to self-isolate with a positive diagnosis and retention of the requirement to wear face coverings in communal areas of health and care settings.

213. When I next attended the Cabinet meeting on 12 April 2022, there were high levels of infection in Wales: 1 in 13 people had Covid-19. There was still pressure on the NHS although ICU admissions were lower than in previous waves. I had written a statement dated 7 April 2022 to inform the decision making at this meeting. I note that part of my statement which advised the retention of face coverings in hospital settings was also included in the Ministerial advice which was provided to Cabinet for this meeting. My advice was that we should maintain our efforts to reduce transmission within hospital settings. Limiting visitor numbers to hospitals, maintaining social distancing, and rigorous application of infection control procedures all remained important in my view. Whilst I acknowledged that face coverings for visitors would only have a small additional effect on reducing viral transmission, they also signalled the need for continued protective behaviours. I felt that they should continue to be used by staff and visitors until viral transmission in the community was significantly reduced. I said that it was unclear whether this would best be achieved through continued legislation or guidance but noted the rapid behavioural changed which had been seen in Wales when the shift to guidance had occurred in other settings such as retail and hospitality. I also gave advice on preparing for future resurgences over the summer and into the autumn. My view was that we should expedite enhanced surveillance in hospitals (through Public Health Wales's Surveillance of Acute Respiratory Infections ("SARI") programme) and through an expansion of sentinel sites in primary care. I cautioned against assuming that future variants would be as relatively benign as Omicron and recommended that we plan our response to future surges on the basis that they would be more harmful. I also suggested that we should review our arrangements for protecting vulnerable individuals and groups and continue to follow JCVI advice with regard to further vaccination boosters.

214. I was unable to attend the Cabinet meeting on 23 May 2022 but Chris Jones, the DCMO, attended on my behalf. I issued a public statement after this meeting dated 26 May 2022. I note that the Ministerial Advice which was available to Ministers at the meeting contained a summary of my advice in the following terms: infection rates continued to wane and high level of vaccination in Wales meant that limited numbers of people were experiencing direct harm; it was therefore timely to remove the remaining legal requirement for face coverings in health and social care settings. I noted that many hospitals in other UK nations were successfully promoting the continued use of face coverings and limiting visitor numbers in health care settings and I recommended that a similar approach was adopted in Wales.

Decisions which the CMO(W) advised against or disagreed with

215. I do not recall any significant decisions (with the focus on those key decisions or measures taken) which the Welsh Government made during the specified period which I advised against or disagreed with. I gave my advice objectively and with full acceptance that I was not the decision maker and was not the only adviser to ministers. I have outlined the position with face coverings above. I would not necessarily have mandated their use, but I recognised the impact their use had on signalling behaviour among the public which helped to maintain social distancing which in my view was an important measure.

216. Another area I had concerns about was the length of the firebreak in October 2020. Ideally this should have been longer to see any real impact. The decision was made that it would be 2 weeks, while I would have preferred a 3-week minimum, but I understood ministers were restricted to do what they could given the financial resources that were required for a longer firebreak and the need for funds from UK Government to implement this for that period.

217. In terms of UK decision making, I was not part of the UK process or consulted by the UK government in relation to the decisions taken. As outlined in this statement I had a good working relationship with Profess Chris Whitty and the UK CMOs met regularly and agreed UK Alert Levels, but this was done without regard to the decisions in each of the four nations. In respect of other decisions by the UK Government, significant or otherwise, I was not represented or consulted in the decision-making process.

Level of funding

218. As I have outlined in this statement my role was to provide to ministers information on the public health situation in Wales. The level of funding from the UK Government was not a factor in this advice. Officials advising on the options available to ministers in their strategic response to Covid-19, including decisions to impose NPIs, or to amend, extend, or end their use would include information on the financial implications but that would not be a matter for myself or my office. I do not recall any discussions directly with Jonathan Price, the Chief Economic Advisor for Wales about the availability or level of funding when formulating advice which I provided to the Welsh Government, however from the start of the pandemic Jonathan was asked to chair the Technical Advisory Cell Subgroup on Socio-Economic Harms. I engaged with Jonathan and his team in relation to the fourth harm, the economic harm, as described above in paragraph 134.

5. NPIs and vulnerable groups

219. It was recognised early on that the risk of severe disease and death would likely be increased among elderly people and in people with underlying health risk conditions, much in the same way as is the case with influenza.

220. On 16 March 2020 the Welsh Government, in conjunction with the UK Government, announced a package of measures, advising those who are at increased risk of severe illness from Covid-19 to be particularly stringent in following social distancing measures.

221. The group initially identified as at increased risk of severe illness from Covid-19 were those who were:

> aged 70 or older (regardless of medical conditions)
>
> under 70 with an underlying health condition listed below (ie anyone instructed to get a flu jab as an adult each year on medical grounds):
>
> chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis
>
> chronic heart disease, such as heart failure
>
> chronic kidney disease
>
> chronic liver disease, such as hepatitis

chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), a learning disability or cerebral palsy

diabetes

problems with the spleen – for example, sickle cell disease or if you have had your spleen removed

a weakened immune system as the result of conditions such as HIV and AIDS, or medicines such as steroid tablets or chemotherapy

being seriously overweight (a BMI of 40 or above)

those who are pregnant

222. This group were not proactively contacted but were asked to take steps to reduce their social interactions to reduce the risk of transmission of coronavirus.

223. On the 24 March 2020, I wrote to almost 100,000 people who had been identified as most vulnerable and advised them to stay at home for 12 weeks exhibit **FAM2BCMO/30- INQ000226987**. This list included people who had had transplants, people on certain cancer treatments and those with severe lung disease. The criteria for who should be considered to be at highest risk of mortality and severe morbidity from Covid-19 was based on emerging clinical data about Covid-19 received via SAGE which indicated that the death rate would be high for groups of people with particular chronic diseases. The modelling suggested that if we were able to effectively shield these people it would have a significant positive effect on the fatality rate in that group and overall (but a modest effect on the overall curve).

224. The list of patients were drawn up by extracting relevant groups from national datasets held by the NHS in Wales and using the work the NHS England Clinical Reference Groups (groups of experts who advise the NHS on Direct Commissioning) undertook to consider which conditions would put patients at intermediate, high or very high risk of severe morbidity or mortality from Covid-19. We then created an expert group consisting of specialist and wider advice senior clinicians from across the NHS in Wales and categorised these conditions into high risk groups.

225. I advised General Practitioners in Wales on the 24 March 2020 in public health link CEM/CMO/2020/09 that given the difficulties of identifying those most vulnerable, in some cases this is going to require clinical judgements by GPs about their patients, as

they may know of specific additional patients in their practice who are particularly high risk or equally who would not require/suit being under such strict isolation for a prolonged period exhibit **FAM2BCMO/31 - INQ000066204.**

226. The Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 came into force on 26 March 2020, and were subsequently replaced by The Health Protection (Coronavirus Restrictions) (No. 2) (No 3) (No 4) and (No 5) (Wales) Regulations 2020 ("the Restriction Regulations"). While the Restriction Regulations applied equally to those shielding as to those not advised to shield, where restrictions were eased or removed when shielding advice was still active this would not necessarily have applied to those asked to shield. For example, shielding advice was in place up to the 16 August 2020 however throughout July 2020 restrictions for non-shielding individuals were slowly eased with the opening of outdoor, then indoor hospitality and hairdressers/barbers. Responsibility for advising this group sat with the CMO(W) office.

227. On the 23 April 2020 I received advice which I had commissioned from the NHS Delivery Unit assessing the shielding patient list. This was prepared by a small working group of colleagues across the NHS Wales Informatics Service and the NHS Delivery Unit in conjunction with Dr Mark Walker, Primary Care Senior Medical Officer. The advice identified some differences in the inclusion criteria in Wales and the other home nations, compounded by different methods of searching and addition to the master list. Having reviewed the paper I advised the MHSS that Wales should align our lists with the other UK nations noting that this would result in an increase to the number of people asked to shield. As a result, approximately 21,000 patients have been added to the Welsh Shielded Patient List (taking the number advised to shield in Wales to approximately 121,000).

228. The UK CMOs aligned advice on the criteria for the shielding list so on 1 July 2020, in line with the other CMOs I advised Ministers to follow the advice of the Royal College of Paediatrics and Child Health (RCPCH) to remove most children from the shielding list subject to a clinical assessment.

229. These individuals made a huge sacrifice, together with their families, in an attempt to safeguard themselves from the effect of Covid-19 and to protect the NHS from becoming overwhelmed. I was acutely aware of this group's sacrifice and sought to minimise the impact where possible while ensuring they had appropriate advice on what measures they should take to stay safe. When I wrote to those who are shielding

asking them to continue to do so until 16 August 2020 I committed to ensuring shielding would be reviewed on a three weekly basis, alongside the Restriction Regulations. Specific advice was provided from my office on the shielding cohort as part of that review period and an impact assessment published.

230. An integrated impact assessment of the shielding programme was produced and published on the 19 August 2020 and exhibited in **FAM2BCMO/32- INQ000066205**. Shielding was not fully reintroduced after August 2020 but we continued to support this group. I would ensure that there was appropriate advice to the clinically extremely vulnerable ("CEV") (i.e. those previously advised to shield) particularly in light of the emergence of variants of concern which prompted advice in December 2020 that this group should take additional steps to protect themselves. This advice was lifted on the 1 April 2021.

231. On the 5 August 2021 following a review of the data available since the beginning of the pandemic, the UK CMOs agreed that those under 18 should no longer be considered CEV and should be removed from the shielding patient list.

232. On the 9 September 2021 the UK CMOs agreed that that shielding advice to the CEV group should no longer form part of the Covid-19 response and that it was appropriate to return to the pre-pandemic approach of individual clinical advice. On the 31 March 2022 shielding programme in Wales officially closed

233. In respect of other vulnerable groups, from May 2020, in all parts of Welsh Government and our health and social care systems, discussions began on how we could start the process of recovery whilst not risking an increase in cases and whilst still ensuring that we were prepared for a second phase of the pandemic that might be to come. Informing these decisions was the understanding we had developed about the four harms from Covid-19 as outlined above in paragraph 86.

234. The first three harms were clear from the outset of the pandemic but the fourth less so immediately but we were starting to see increasing evidence that the wider economic and societal effects of our response to the pandemic were creating harms, ranging from economic effects such as job losses, effects of school closures on children and effects of isolation and loneliness, particularly for vulnerable groups. It was also becoming apparent that these effects were not being felt equally and might in fact be widening existing health inequalities and inequities in our society.

235. The Welsh Government also considered the impact of non-pharmaceutical interventions and the restrictions in detail in the regulatory impact assessments for the Health Protection (Coronavirus, Restrictions) (Wales) Regulations and as part of the 21- day review process.

236. The Core Covid-19 Group also sought views from a range of stakeholders with updates and information provided by the Wales Centre for Voluntary Action which invited the views of various charities and third sector support groups to be presented to Ministers and the Black Asian and Minority Ethnic Advisory Group was also invited on several occasions to feedback. I also met with stakeholder groups such as Disability Wales and would also as part of my public health updates to the CCG and Cabinet outline the risk of harms to the general population as well as specific vulnerable groups.

6: Parliamentary evidence

237. I have given evidence to the Senedd's (Welsh Parliament) Health and Social Care Committee[3]) ("the Committee") on a number of occasions both through their formal and informal sessions. A transcript of the formal sessions is produced and published on the Committee website.

238. I attended the Committee on the 18 March 2020 to provide a further technical briefing on Covid-19 this time with Rob Orford. A copy of the transcript for this attendance is exhibited in **FAM2BCMO/33- INQ000066272**. We provided a committee paper on the Welsh Government's reposes to the current Covid-19 epidemic which outlined the interventions put in place from the 16 March 2020 and the scientific and technical rationale for those interventions. A copy to this is exhibited in **FAM2BCMO/34-INQ000239638.** This time the session was not closed to the public and following a summary of current public health situation I took questions from the Committee. The Committee was understandably interested in testing, in the availability of tests and the time taken for results to be processed. The Committee also addressed questions to me about NHS capacity, ventilators and personal protective equipment for NHS staff.

239. The technical briefing session was followed by a session on the emergency legislation, the Coronavirus Bill. This was not a workstream that I or my team were involved in. This was being led by Neil Surman, Deputy Director in the Public Health

[3] Formerly the Health, Social Care and Sport Committee under the Fifth Senedd.

Division under the direction of the MHSS. Myself and Rob left the meeting shortly before this agenda item began.

240. The Committee on 30 April 2020 was an evidence session with myself and Rob Orford. A copy of the transcript for this attendance is exhibited in **FAM2BCMO/35-INQ000087990**. The questioning of the Committee centred on the pandemic response so far and anticipating the future phase. Questions by the committee addressed the links with SAGE, UK counterparts and international offices, and how we approached the contextualisation of the science, including that coming from SAGE, for Wales. I also took particular questions on the advice on shielding, testing and care homes. The overall advice or message to the Committee was that this was an evolving picture and that we continue to learn from others and adapt our strategy and approach as needed.

241. On the 30 September 2020 I accompanied the MHSS and Deputy MHSS to an evidence session. A copy of the transcript for this attendance is exhibited in **FAM2BCMO/36- INQ000087996**. Dr Andrew Goodall, Director General of HSSG and Chief Executive of NHS Wales, Albert Heaney, Deputy Director General of HSSG and also Jo-Anne Daniels, Director of Mental Health, Vulnerable Groups and NHS Governance also attended. The agenda included the Committees inquiry into Covid-19-19 but also wider health service issues such as the new Velindre Cancer Centre and the UK Government's Medical Devices Bill.

242. I attended the Committee on 3 March 2021 to support the MHSS who had been asked to provide an Covid-19 evidence session. A copy of the transcript for this attendance is exhibited in **FAM2BCMO/37- INQ000066269**. This was primarily for the Minister to address questions, but I provided additional input on the mortality rates, non-Covid-19 related treatment and deaths and guidance from the Joint Committee on Vaccination and Immunisation.

243. The Committee on 23 September 2021 a general Covid-19 scrutiny session. A copy of the transcript for this attendance is exhibited in **FAM2BCMO/38 - INQ000066268**. I provided to the community a high-level update on where Wales was, which was in a position of high community transmission which was having an impact on hospital admissions but not to the extent we saw in the first and second waves. I provided some early warnings about winter pressures on the NHS and information around vaccination.

244. The informal Health and Social Care Committee briefing sessions ran monthly during the period November 2021 to March 2022. These sessions were led by the MHSS who was accompanied by a TAC representative and the DG HSSG. I attended these informal briefings to support the Minister whenever possible. I do not hold any notes or papers in relation to this.

245. I attended the UK Parliament's Science and Technology Committee on the 24 April 2020 with the other three CMOs to give evidence to the committee. A copy of the transcript for this attendance is exhibited in **FAM2BCMO/39-INQ000282313**. Part of what was discussed was the working relationship between the four CMOs with us all agreeing that there had been very good interaction highlighting as well that the senior clinicians group had been absolutely invaluable in understanding some of the operational detail. In response to questions by the committee I did however outline that there was a distinction between the sharing of science and understanding and the sharing of policy. Not all policy issues were discussed in detail across the four nations. Often broad strategy will be agreed and discussed through the four CMOs group and the senior clinicians group, but the practical details may not be at that forum.

Reflection/review

246. The process of writing this statement has given me the opportunity to pause and reflect on what was the most challenging and busy time of my career to date. I have tried to remember faithfully the information I had and the advice I gave. The pace of action required, particularly in the early days of the pandemic when so little was known about the virus and its potential impact, placed extraordinary pressure on a small number of dedicated staff in Welsh Government and Public Health Wales. While they should be proud of the work they have done to mitigate the worst of the impacts, we will not forget the enormous sacrifices made by the people of Wales, many who felt considerable anxiety, worry and fear for themselves, families and neighbours and of course those who also sadly lost loved ones as a result of Covid-19.

247. Within the Welsh Government there have been a number of lesson learned exercises which have taken place. As a member of the HSSG I will have been sighted on these, particularly as part of the Executive Director Team meetings. In terms of those reviews which I and my office have been involved in, authored, overseen or responded to, I have detailed these below.

Review of Health Protection Arrangements in Wales

248. In order to learn from our experience of the pandemic I commissioned a review of our health protection arrangements in Wales. This is the main lesson learned review that I and my office have been involved in. The review was conducted by NR - Professor of Infectious Disease Epidemiology at the London School of Hygiene and Tropical Medicine and Head of the Centre on Global Health Security at Chatham House, London - and Sara Hayes who was formerly Director of Public Health at Abertawe Bro Morgannwg University Health Board.

249. The final report was published on the 6 February 2023, a copy of which is exhibited in **FAM2CMO/40- INQ000177516.** The purpose of review was to:

    i. identify the underpinning principles of a robust high performing health protection system;

    ii. assess the strengths of the Welsh Health Protection System against the established benchmark of a high performing health protection system; and

    iii. provide reasonable and actionable recommendations on the ways in which the health protection system in Wales could be further strengthened to meet or exceed the gold standard benchmark.

250. The review limited its focus to health protection. The reviewers were clear that the health protection system in Wales is not broken and is not dysfunctional but there are things we can do to strengthen it further. The key overarching recommendations include:

    i. Ensure that backlogs in health services and public protection services are cleared and remain manageable, and do not lead to deterioration in the public's health and wellbeing, so ensuring more healthy people who are less vulnerable to infectious disease threats.

    ii. Maximise the health and therefore resilience of the population through health and wellbeing initiatives and the recovery of NHS and Public Protection services which have been impacted by Covid.

    iii. Accountability frameworks should be developed so that for any population data, inequalities can be routinely monitored, and actions can be designed to tackle them.

iv. Ensure that health board Public Health teams and local government Environmental Health teams have clarity on their respective core roles and responsibilities. We strengthen the system including use of behaviour science, risk communication and infection prevention and control.

v. Local resilience for all-hazard health protection needs to be retained following recovery from the Covid pandemic. For a local disease control or response team to be effective it needs support from both health protection specialists, public health laboratories and field epidemiologists. This multiagency relationship can be strengthened through joint training.

vi. The voluntary sector should be engaged nationally and locally to explore what contribution volunteers may make in endemic disease control and future significant events.

vii. Continue to bring the wider system, from the local to the regional and national levels, together in routine disease control activities, and in exercising and training for emergencies so that it works as one system and does not become fragmented. Health protection and civil contingency plans should be tested through exercises, with staff from all levels of the organisations taking part.

viii. Discussions should be initiated with universities and other tertiary education providers to explore mechanisms to engage students on health-related courses to support health protection and participate in present and future all-hazard exercises and responses.

ix. Ensure communication systems can operate in all directions, not just one way, to provide feedback and allow recipients to engage fully.

x. Review all data systems currently operating and explore how they can operate to agreed, shared standards and be combined, within the confines of Data Protection safeguards, to aid data capture and to increase their value in national and local surveillance.

xi. Continue and strengthen four nation and international links and academia, for stronger horizon scanning, anticipation of emergency events, and identification of needs for better routine control.

251. The implementation work will be overseen by the Health Protection Advisory Group ("HPAG") which I chair. An Implementation Plan was produced and I exhibit a copy of

this in **FAM2BCMO/41-INQ000252577** The plan will build upon previous assessments, recommendations and improvements to the public health system undertaken by Welsh Government and including the work of Audit Wales and the technical report on the COVID-19 pandemic by the UK's Chief Medical Officers. The two reviews referenced in this statement are the main ones I have been involved in, commissioned, authored, overseen or responded to but there have been others within the HSSG in Welsh Government. We aim to address the recommendations in a thematic way, ensuring we take forward the more detailed recommendations in the report alongside the overarching thematic recommendations outlined in this plan. Work will reflect the "One Wales/Health" approach. An update on work to address both the overarching recommendations and those more detailed recommendations will be published later in 2023.

252. Other reviews that myself or my office engaged in are detailed below:

Reviews of the HSSG response structure

253. Andrew Goodall and I commissioned a report entitled 'Review of the Health and Social Services Group Response Structure to Covid-19' dated 25 September 2020, exhibited in **FAM2BCMO/42 – INQ000066465**. The purpose of the review was to identify learning from January to September 2020 to strengthen the HSSG's Covid response in the immediate term and to inform emergency planning arrangements for the future. It was compiled from survey responses from HSSG staff, key individuals, subgroups and cells, and focused predominately on internal organisational structures. The recommendations of particular relevance to the CMO office included:

    i. HSSG to consider its contingency structure for resurgence of COVID-19/winter and review and update the COVID-19 Planning & Response Framework accordingly in readiness for the next phase of the pandemic response, as well as providing a template for any future public health emergencies.

    ii. Consider the role that an NHS Executive function should have in our emergency response in providing a formal and resourced interface between HSSG and NHS organisations.

    iii. Review the protocol with PHW and also the structure and staff resilience of the Public Health Division to deliver health protection and emergency planning functions.

iv. Clarify with DHSC the structure for 4 countries co-ordination of the response through the winter and for future national emergencies.

v. Establish a stakeholder group to review the significant challenges of managing information and dealing with enquiries so that improvements are made and there is a clarity of the process going forward through winter.

vi. Consideration is given to the structure for engaging with stakeholders that has been at the core of our response to COVID thus far, through the next phase of COVID and in the longer term for routine business. The proposals for the creation of an NHS Executive should be integral to these considerations.

254. A second Review of the Health & Social Services Group Response Structure to Covid-19 dated 11 October 2021, as exhibited in **FAM2BCMO/43– INQ000022616.** This updated on the previous recommendations, confirming that 10 of the recommendations of the September 2020 Review had been implemented, while six were progressing. Further recommendations were made, including that strategic decision-making within the EDT, the Planning and Response Group and its sub-groups should include structured consideration of the five COVID-19 harms (direct harm from Covid-19 infections, indirect harm, harm from protection measures, economic harms and harms increasing inequalities).

Shielding

255. A lessons learned review of the implementation of shielding policy from March 2020 to June 2021, is exhibited in **FAM2BCMO/44– INQ000066553.** This identified a number of recommendations to ensure an efficient, streamlined and well-communicated approach for any future shielding. These included:

vii. Ensure a clear point of contact is available for recipients of shielding advice. This could take the form of a contact centre. GPs should also be aware of this contact point, as well as specific guidance for them in how to support patients advised to shield.

viii. Prioritise strong working relationships with stakeholders, including local authorities and community voluntary councils from the outset, and with counterparts in other UK nations.

ix. Prioritise the use of accessible formats, including providing easy read alternatives as standard and translation to other languages as appropriate

(including British Sign Language), ensuring appropriate expertise is in place to advise on complexities of translating medical language.

x. Work with UK Government to pursue an 'emergency response' objective for the Data Sharing powers in the Digital Economy Act to aid in the response to future emergencies and seek to align policy approaches across UK nations to support consistency of messaging.

xi. Critically review stakeholder engagement and governance structures periodically to identify any areas of omission (important to ensure representation from health and local authorities).

256. Internal audit service reports were carried out in relation to the schemes to provide medicine to the shielded (exhibit **FAM2BCMO/45– INQ000022589**, dated October 2020), and in relation to the shielding food parcel scheme (exhibit **FAM2BCMO/46-INQ000022582**, dated September 2020). While the CMO Office did not deliver on these aspects of the shielding programme we noted the observations included that, should there be a reintroduction of the scheme, there should be an increased focus on promoting the use of shielded persons' support network as an alternative to requesting food parcels.

TAG 'wash up' report

257. On 6 May 2022 the Technical Advisory Group held a 'wash-up event' to discuss the subgroups' experience around the provision of science advice, their membership and expertise and lessons learnt over the course of the pandemic. The resulting report is exhibited in **FAM2BCMO/47– INQ000313383** identified a number of recommendations, including:

xii. Welsh Government officials should work closely with UK Government counterparts and other UK level organisations to allow access to advice and visibility of other groups.

xiii. Improve sharing of evidence outside of Wales and ensure appropriate attendance at all UK level subgroups and meetings.

xiv. Consider the utility of an evidence synthesis and rapid primary review function, like the Wales Covid-19 Evidence Centre, beyond Covid to support decision making both in non-emergency and future emergency contexts.

xv. Review and improve the co-ordination of communication and information flows from subgroups to the main TAG and vice versa.

xvi. Clearer processes for commissions for new advice and finalising papers for publication to aid efficiency and manage demand.

Treatment pathway and essential services

258. A report entitled 'Lessons Learnt: COVID-19 Treatment Pathway and Essential Services' exhibited in **FAM2BCMO/48– INQ000066566**, identified a number of learning points. Following the success of the critical care network, the report recommended that consideration should be given to the establishing of a formal clinical network for respiratory medicine in managing the Covid secondary care response. The report noted that a review of national clinical networks was already underway and the development of a respiratory medicine network was under consideration. Following delays in establishing a central data entry platform and problems creating a national dataset of COVID care and outcomes on COVID and respiratory wards, the report also recommended taking part in UK-wide extensions to existing clinical audit programmes where feasible.

The Nosocomial Transmission Group

259. The importance of learning lessons relating to the spread of Covid-19 within closed settings, such as hospitals and care homes, was identified early in the pandemic. Consequently, the Nosocomial Transmission Group (NTG), jointly chaired by the Chief Nursing Officer and Deputy Chief Medical Officer, was established in early May 2020. The group had a broad membership drawn from health and social care and has met frequently throughout the pandemic. The group has continuously reviewed core COVID-19 data concerning hospitals and care homes and issued guidance updated in the light of this continuous learning.

260. The NTG developed and issued an extensive range of guidance on implementing infection prevention and control guidelines, personal protective equipment, COVID-19 testing, cleaning standards, bed spacing, ventilation and environmental controls. Throughout the pandemic, via membership of the UK Infection Prevention and Control (UK IPC) group, Wales has played an active part in the development and continual evaluation of the UK evidence based IPC guidance. This has worked as a dynamic system, developing in response to new and emerging evidence.

261. The Nosocomial Transmission Group also supported the development, by the Delivery Unit, of the 'Covid-19 Rapid Sharing of Early Learning' ('CoRSEL') system, which aimed to learn and share lessons in close to real time during the first wave of the pandemic, and the 'NHS Wales national framework – Management of patient safety incidence following nosocomial transmission of Covid-19' which was used by health boards to investigate and learn from incidents of harm from nosocomial transmission of Covid-19.

UK CMOs Technical Report

262. My fellow CMOs and I have also worked together to produce a document aimed at the CMOs, Government Chief Scientific Advisers (GCSA / CSAs), National Medical Directors and public health leaders of the future should they find themselves faced with a new pandemic or major epidemic. It covers some technical aspects of interest primarily to our scientific, public health and clinical successors. Any future pandemic will present its own unique challenges but the document sets out what we learned from this pandemic. A copy of this report was exhibited earlier in this statement in exhibit **FAM2BCMO/07-INQ000177534** and has been used as a reference for parts of this statement.

263. We know that Covid-19 has deepened inequalities and we have seen its disproportionate impact on some of the most vulnerable people in our society. We must use our experience of Covid-19 to reset and improve action aimed at improving our health across the whole of society. The pandemic has shown the interconnectivity of our world and how quickly everything we take for granted can be brought to a halt; equally it has shown us how resourceful and adaptable we all are and how we can find solutions to seemingly intractable problems.

264. My greatest fear is that the competing pressures which Wales is currently exposed to through economic recession, rising costs of living, increasing energy costs, war in Europe, and climate change will divert attention and investment away from the opportunity which we now have to build a more resilient system for protecting the heath of everyone in Wales.

265. A number of challenges now face public health in Wales. Covid-19 is still with us and remains a serious public health challenge. In addition, we see emerging the legacy of the direct harm of the virus in the form of long Covid and the indirect harms to

people's health. The people of Wales have faced the challenges of Covid-19 with remarkable resilience and understanding; many have made great sacrifices. I am grateful to them.

266. Above all at the end of this statement I would like to remember those who died from Covid-19 and their families. As a doctor with a life-long passion for public health I recognise the losses and sacrifices that have been endured by so many and I hope that the lessons learned through this inquiry will also serve to strengthen our protections against future threats to the health and wellbeing of people in Wales and across the other nations of UK.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Full name: Frank Atherton

Position or office held: Chief Medical Officer for Wales

Signed: **Personal Data**

Date: 18 December 2023