Tuesday, 5 March 2024

(10.00 am)

MR POOLE: Can I call Dr Andrew Goodall.

DR ANDREW GOODALL (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2B

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

A. Bore da, good morning, I'm Andrew Goodall.

Q. Dr Goodall, if I can ask you whilst you are giving your evidence just to keep your voice up so we can hear you, but also, importantly, so your evidence can be recorded. If I do ask you a question you don't understand, please ask me to rephrase it.

Thank you for attending today and assisting the Inquiry. You have kindly provided a total of five witness statements to this module. The first witness statement, dealing with the Welsh Government, is dated 21 September 2023. The second witness statement, dealing with the Welsh Treasury, is dated 22 September 2023. Your third witness statement deals with the Health and Social Services Group, and that's dated 29 September last year. Your fourth witness statement deals with the NHS in Wales and is dated 4 December last year. And then your fifth witness statement, which is your personal witness statement, is

dated 8 January of this year.

Each of those statements is signed by you with a statement of truth. Can you confirm that the contents of each of those statements is true to the best of your knowledge and belief?

A. Yes, I can confirm that.

Q. You've also kindly provided three witness statements to Module 1 of the Inquiry and you also gave evidence in Module 1 on 3 July 2023. That's correct, isn't it?

A. That's correct.

Q. I think it would be fair to say, Dr Goodall, you have gone above and beyond to provide us with as much information as you possibly can about the workings of the Welsh Government and, importantly for us this morning, the NHS in Wales, for which we are very grateful.

In terms of your professional background, you have a law degree from Essex University, a PhD in health service management from Cardiff Business School, Cardiff University; is that right?

A. Yes, that's correct.

Q. Between 2009 and 2014 you were the chief executive of the Aneurin Bevan University board. Since June 2014 you have been the director general, Health and Social Services and also the chief executive, NHS Wales, and

then in September 2021 you were appointed to the role of the Welsh Government permanent secretary. You took over that post in November 2021, taking over from Dame Shan Morgan, who we heard from yesterday afternoon. Is all of that correct?

A. Yes.

Q. Dr Goodall, although you are currently the permanent secretary to the Welsh Government, the focus of my questioning this morning will be on your role as director general of the Health and Social Services and also chief executive NHS Wales during the pandemic.

If I can start then with some questions about those two roles, I will come on to the responsibilities of both of those roles in a bit more detail a bit later on, but can you just explain to us how it came to be that you held both roles at the same time?

A. In Welsh Government the NHS Wales chief executive role is also the director general of Health and Social Services, so it's a role that is located in the civil service, but it has the responsibilities for the NHS through leadership and oversight responsibilities.

Within that role it's really important to say that the director general responsibilities are supporting ministers of course, but it means that the NHS in practical terms is line managed by Welsh Government.

Q. So would it be right in saying that the NHS Wales role is essentially an outward facing role whereas the director general role is primarily inward facing?

A. Yes, that's right. I oversaw all of the health organisations in Wales, but in many respects I acted as the NHS voice and I would have been speaking, for example, more publicly on a range of areas in that NHS role and then internally looking to support ministers in their advice.

Q. I'd like to ask you now about the structure and the operation of the NHS in Wales. Now, as we all know, healthcare is obviously a devolved matter, so as a consequence of that the Welsh Government has overarching responsibility for the NHS in Wales; that's right, isn't it?

A. Yes, that's correct.

Q. So in practical terms during the pandemic did this mean that decisions concerning and impacting the NHS in Wales were taken by the Welsh Government without having to have recourse to Westminster?

A. Yes, they were taken at Welsh Government level.

Q. Can we, please, look at INQ000177485.

This is a, as it says at the top, governance map of NHS Wales. Just before we start looking at this map, I'm right in saying there's no legal entity called

NHS Wales, is there? That's really a shorthand to describe a number of different entities that all comprise the NHS in Wales?

A. Yes, NHS Wales is established through the 12 statutory organisations that exist, but because of the line management responsibilities of Welsh Government, it is a shorthand description.

Q. If we focus then on the top half of this page, we see right at the very top the Welsh Government, we see the director general, chief executive role to the left. We then see the minister with responsibility for Health and Social Services, so that's Mr Gething at the start of the pandemic and later Eluned Morgan, and we see the Health and Social Services Group, which we'll hear a bit more about later about in your evidence.

Below that we have three NHS trusts, seven health boards, two special health authorities, which again, as shown in this diagram, are collectively known as the NHS bodies.

Those bodies and those who they contract with to provide a range of primary and secondary and tertiary care and community services, that is what, as you've just described, comprises the NHS in Wales?

A. Yes, that's correct.

Q. In terms of funding, the NHS Wales is funded by the

Welsh Government; is that right?

A. Yes, correct.

Q. What is the role of the NHS Wales executive board? Now I think it's known as the NHS Wales leadership board.

A. Every organisation has its own statutory responsibilities, the NHS executive board was a way in which I was able to bring colleagues together from across the NHS, the chief executives of those individual bodies, alongside my own internal director team sitting within the Health and Social Services Group. So it allowed us to have an oversight role on the system leadership and to bring the collective understanding of delivery and actions across Wales together. It also allowed us the time to, whilst recognising operational issues, look forward for the NHS in Wales and make sure that we had future plans and strategies.

Q. What duties does NHS Wales have in respect of the public sector equality duty and completing equality impact assessments?

A. There's a duty for Welsh Government on equality impact assessments, but every organisation would also have its own equality responsibilities under that legislation, so the 12 individual health organisations would have their own responsibilities too.

Q. I move on to next your role as the director general of

the Health and Social Services Group. Can you perhaps sensibly start with just tell us, what is the Health and Social Services Group?

A. The Health and Social Services Group is one of the departments within Welsh Government. We organise ourselves around ministerial responsibilities and portfolios. It means that we are able to divide up the civil servants in Welsh Government, and allow ourselves to give appropriate support and advice to ministers.

Obviously there are individual directors and teams who sit within that group as well and they have their own individual responsibilities also, but fundamentally it's about supporting ministers in the role, and in this case it was the health minister, who of course, as you've said, was Vaughan Gething at the time.

Q. So as well as providing a sort of leadership role for the NHS, does it provide a link also between the NHS bodies that we've just been looking at and the Welsh Government?

A. Yes, it acts as an immediate contact point, so irrespective of my own NHS Wales chief executive role, you would find civil servants interacting very regularly and daily with a range of organisation, in Wales and indeed professional bodies as well. So it was to bring together that understanding in health intelligence in

Wales and to use that to support our policymaking.

Q. In your personal witness statement you list your many responsibilities as director general of the HSSG during the pandemic. If I may, just to highlight a few that are of direct relevance to this module, is it right that you were responsible for enabling intergovernmental decision-making for health and social care?

A. Yes.

Q. Overseeing how health and social care policy decisions were made, communicated and implemented?

A. Yes.

Q. Overseeing the availability and use of data and evidence in decision-making?

A. Yes.

Q. Overseeing preparedness, NHS capacity and the ability to increase capacity and resilience?

A. Yes.

Q. And overseeing the pandemic response in all health settings, so that includes in respect of infection prevention, control, triage, critical care capacity, patient discharge, the approach to palliative care, workforce testing and inspections?

A. Yes.

Q. And you also contributed to evidence which informed decisions on the use of lockdowns and other NPIs?

A. Yes.
Q. In your role as director general, you were also part of the permanent secretary's senior team. Did this bring any additional benefits to discharging either of your roles as director general or chief executive of the NHS?
A. Given that I was located in the civil service and a director general, it meant that I was able to bring conversations about health into the wider Welsh Government structures, so working alongside my other director general colleagues, also working in support of other ministers, so there were genuinely advantages about being part of that senior leadership team. But I did have to look outward to the NHS and provide support there, but it also meant that I was able to access support and indeed support others within the Welsh Government team too.
LADY HALLETT: Can I just interrupt? You're both going very quickly and I don't want to end up with complaints from the stenographer.
MR POOLE: My Lady, I will try to slow down my questions.
Dr Goodall, what was the relationship between yourself and the Minister for Health and Social Services?
A. I reported directly to the Minister for Health and Social Services in respect of my oversight of the NHS

and my director general responsibilities, so he was my lead minister. It meant that I had frequent daily, sometimes throughout a day, contact with the minister, and it was an important relationship to be able to respond to his requirements and make sure that my policy teams were supporting ministers appropriately.
Q. If we can, please, have on screen INQ000083227. I'm grateful.
This is an organisational chart with which the Inquiry is now very familiar. We can see you as one of the four director generals. Below you we can see the prominent individual within the HSSG. We see the CMO, Dr Atherton, sits within the HSSG.
Not shown on this chart, did the Chief Scientific Adviser for Health, so Dr Orford, did he sit within the HSSG?
A. He was located within the Health and Social Services Group in a deputy director role prior to the pandemic.
Q. And the CMO and the Chief Scientific Adviser for Health, who were they accountable to?
A. The Chief Medical Officer was accountable to myself. Frank also had a director of health protection role sitting in my structures. The deputy director role, which was the Chief Scientific Adviser for Health, reported to one of my directors, so pre-pandemic this

was Frances Duffy, who is listed on your screen, the director of Primary Care and Innovation.
Q. Taking them in turn, perhaps dealing with Dr Atherton first, can you briefly describe your relationship with Dr Atherton throughout the pandemic, specifically in your capacity as director general?
A. Frank had a lead role as our Chief Medical Officer. I was always mindful that he had a Cabinet adviser role irrespective of the line management to myself, so that afforded him a different level of contact within the organisation. I was his line manager, so I was there to support the role of the population health team, and Frank and I had very regular contact, both individually and collectively, as you would expect, through the pandemic. Often many times through the day. Often we were located working within our Cathays Park offices with the very limited staff that were available as well. But it was a very frequent contact, as you would expect, with Frank.
Q. And Dr Orford, your contact and relationship with him during the pandemic?
A. So through the pandemic it was very much enhanced from my previous contacts with Rob, which would have happened through his previous role, but of course given the extraordinary role that he discharged for us through the

pandemic response I saw Rob, again, very frequently, including around collective meetings like Cabinet and other collective meetings of civil servants, but also that gave me a change to be supporting Rob in his individual role as the Chief Scientific Adviser for Health.
Q. Now, Professor Peter Halligan was the Chief Scientific Adviser for Wales during the pandemic and I think you've said in one of your witness statements you had limited contact with him. Why was that?
A. I had limited contact. He reported to a different director general, firstly, not in the health context, so -- because of the science and innovation brief. As this started off as a health-led response, Rob's role progressed and as we converted from that health-led role we ended up using Rob actually in that more focused Chief Scientific Adviser health role because it linked to the understanding of the pandemic response, and he discharged that very effectively through the pandemic.
Q. Dr Goodall, if I can ask you again, please slow down your natural pace of speech, just so the stenographer can capture all of your evidence. I'm sure it's my fault as well.
In your personal statement you say this about Dr Orford, you say:

"... Rob at times found it difficult to secure the same access to UK-wide networks, UK-level intelligence and the benefits of collaboration and information exchanges with the other UK Chief Scientific Advisers that Peter benefitted from, in terms of future health pandemic planning ..."

And you say this:

"... I believe that it is vital that the significance of the Chief Scientific Adviser for Health's role in Wales is formally recognised and embedded in UK-level preparation and response structures."

So in the event of a future pandemic, this is something that you would like to see changed; is that right?

A. Yes, I would agree. Of course that's in the context of a health response, but I think that's an essential requirement, if -- the devolved administration voices to be properly around the table to and make sure that we have that bridge in place.

Q. The Chief Nursing Officer for Wales was also directly accountable to you in your director general role. Can you briefly describe your relationship with the various individuals that have held that role during your time as director general in the pandemic.

A. Yes, I again had regular contact, I was the line manager of all of my directors in my group, whilst they were discharging professional roles. I had frequent contact with them collectively around the table, with colleagues individually where needed, and was available to give them the support that was required.

With all of the directors in my group, however, I had a very high regard for their abilities and their responsibilities, so it was important that they understood that they could actually act at their own initiative and independently where required.

Q. What responsibilities did you and the HSSG more widely have regarding the care sector in Wales?

A. Within the director general role, we oversee the policy development of social care in Wales, we have a supervisory role. Legal responsibilities for delivering social care services lie with local authorities, but obviously at the national level we oversee the policy development and ministers are supported to make policy decisions, and there was a Deputy Minister for Social Services in place during the pandemic response.

Q. So I think it would be right from what you've just said that the Minister for Health and Social Services, and by extension HSSG, their responsibility really lies in

matters of policy only, whereas operational delivery of care services in Wales, that's the responsibility of Welsh local authorities; is that right?

A. Indeed, and it was distinct from the NHS role, which, as I said earlier, it was a line management responsibility for the NHS.

Q. We know that there are 22 local authorities in Wales. Does that complicate the delivery of care services in Wales? Was that your experience, for example, during the pandemic?

A. There were national voices for local government. Of course every individual statutory organisation needed to discharge its own responsibilities. I was very reliant on the local relationships between local health boards, which had a more regional template, to work very closely with local authorities. But we were able to often get those organisations in a room, both from representatives but actually collectively as well in Wales, and there were very close and effective relationships in place with the local authorities as well. So I don't think that really was a problem, but obviously they are significant numbers of organisations to be involved.

Q. In March 2020 you asked Albert Heaney to take up the post of deputy director general for Health and Social Services. Was that always the plan or was that linked

to the pandemic response?

A. No, that was genuinely linked to the pandemic response, because as we were manoeuvering our way through the response and making progress, I obviously was having to discharge that leadership responsibility for the NHS. But given the policy responsibilities that we held in Wales, it felt really important to make sure that I was able to have that care voice very clearly at the highest level of my group structures and Albert was able to discharge that.

And one of the reasons for doing that was when we were attending meetings Albert was often alongside me and sitting, for example, with ministers, so it just meant that there was a very direct voice that we could use there in support of my role but actually in support of the policy expertise.

Q. In your view would there be benefit from further alignment between the NHS and the care sector in Wales? Is that something that is perhaps already under way or envisaged for the future?

A. Our strategy for Wales, we launched this back in June 2018, is actually to align health and social services in Wales, so actually there is a very clear strategy already in place to do that, and I was part of the development of that plan alongside the minister for

health and social care. So we have a very clear future plan about our intentions.

I think that worked to good effect during the pandemic response as well. But I do think that we have to make sure that we are overseeing appropriately at a national level, because we are very reliant on the local relationships that are in place between local health boards in particular and with the local authority organisations, so there is an operational responsibility to get right.

Q. Having now looked at both roles that you held, would you say in your experience that there was a benefit to one person holding both roles?

A. My personal view as experienced through the pandemic was that it genuinely helped us, it brought a voice of the NHS very intimately into government at a really critical moment of a health -- pandemic response, and I hope I was able to discharge that professionally.

I think there were lots of advantages of being able to bring the system oversight much closer between ministers and the NHS, so I always felt I was able to represent a very proper view, not just of organisations in Wales but actually of healthcare professional voices, of unions and of other representatives as well.

But it's not only my experience of the pandemic

response, my view is that that is something that helped me through the whole of my tenure, and I had to make a decision with my successor about whether I was going to retain that, because this has been the pattern over the last two decades, and in October 2021 I determined that I would keep that responsibility together because I think it had worked very effectively, and visibly so in the pandemic response.

Q. Did one of your roles during the pandemic though take priority over the other?

A. I think whilst there is a balance in looking to support ministers and the director general role, in the middle of a health pandemic inevitably, if you are the NHS Wales chief executive, that has to take a different level of responsibility and oversight. So if I was saying where was the balance, I think I had to step more into the NHS space during the pandemic response, but I don't think that let at all down the access or the availability of advice and expertise for the director general side. I've always been very corporately visible, and I think ministers would say that whilst I was supporting the NHS that I was always available to them whenever they needed for the internal policy development too.

Q. Could we, please, have a look at INQ000182389.

This is an email that you sent on 21 March 2020 asking Jo-Anne Daniels to take on the role of Covid-19 director. If we just have a look at, I think it's the fifth paragraph, second line -- third line in fact, you say:

"I have to protect my nhs role ... [Document read] ... would wish into government areas."

What do you mean by being "drawn more than [you] ... wish into government areas"?

A. I think at that point, which I think was just ahead of the lockdown itself, I was getting drawn in more so into some of the broader interface and policy issues with other government areas, so whilst this was a health-led response, it was actually quite a critical point for the NHS, both in terms of the development of plans and capacity.

I was discharging a visible role in Wales in terms of needing to lead that responsibility with my other health service colleagues as well, and I needed to work out whether there was a better way of giving some of that protection while still having the reporting lines to myself. In fact, having approached Jo-Anne at this time, there are a number of things that had actually happened during -- towards the end of March that actually helped me to make sure that that support was

available. You've already referred to Albert Heaney taking on the deputy director general role. That helped to consolidate support underneath me. Our planning and response mechanisms were working really well and we had military planners in place as well as the broader Welsh Government. So whilst I was having that conversation with Jo-Anne, I think probably the situation actually improved more.

In the end I actually used Jo-Anne just a few weeks later for her to act as the director of test, trace and protect, which is a fundamental objective for us to achieve in Wales, and again she discharged that quite well. But it didn't mean I was removed from the process, it was just trying to make sure I could really show that I was visibly available for the NHS.

Q. Now, you've just referred in your answer to senior military planners. As I understand it, senior military planners were embedded within the HSSG and also other NHS bodies in the course of the pandemic. Can you just briefly describe, what role did they play?

A. Yeah, they really played an extraordinary role and came in very early to our response. So they were available in March. They provided a reference point and support for us on logistics and planning. They helped us with the way in which we could ensure that we had the right

decision-making mechanisms in place. But importantly, as you said, they weren't just available for us in our national role, they actually committed their time and support in every individual health organisation in Wales, and that was used to very good effect on some of the planning for capacity for field hospitals and even, later on, around vaccination areas as well when we were putting in the vaccination systems in Wales.

Q. So in the event of a future pandemic, the use of senior military planners, that is something you would encourage again?

A. I would really encourage it. We were really impressed with all of the colleagues that came to join us in those teams and I think they were essential, particularly at those early stages, to help us with the way in which we were responding to the pandemic.

Q. I'd like to talk to you now about some other various groups that were formed and you attended over the course of the pandemic. We heard yesterday from Dame Shan Morgan a bit about ExCovid. Now, did you have a specific role in ExCovid?

A. I was a director general attending it. Of course I was there with my oversight and leadership of the health response and of the NHS. In terms of the format of the meetings, I would tend to have a role to give an update

on my sense of the pandemic progress, at different stages, of course, during the pandemic response, but also to give an update on the NHS response, whether it was about capacity or the difficulties that the system was experiencing.

Q. In your personal witness statement you say that prior to the pandemic you established weekly executive director team meetings, so they're meetings of the directors in the Health and Social Services Group, and you say that this was to bring together information, identify leadership actions and make decisions across the group's functions and responsibilities. Then you go on to explain that at the start of the pandemic you established the executive directors team contingency group. What was the purpose of that group?

A. So we had a weekly pattern to meet as directors so that we were able to oversee particularly the information that was feeding up from our planning and response mechanisms that were in place.

The reason for introducing the directors contingency group meeting, it was actually something that was introduced later in the pandemic response, in October 2020. At that point, whilst there was still an intensity about the pandemic response, we also had some broader health responsibilities to discharge, not

least as we were returning to some level of normal activity. So that group meant that we were able to protect the pandemic response discussions from some of those wider responsibilities for the health group as well.

So there's an intensity about a pandemic response, but of course you have all of the normal and all the statutory responsibilities to discharge for the NHS system.

Q. I understand.

Also at the start of the pandemic, is it right that you established the Health and Social Services Covid-19 planning and response group?

A. Yes, that had its first meeting on 20 February. It was actually established in response to Frank in his health lead at that time, I think it was in early February, just asking us to make sure that we were putting in a different set of response arrangements. And I think, again, that worked very well really from the outset, to give us a focal point for our attention.

Importantly, though, it gave us a way in which we could anchor ourselves to voices from the NHS system and the care system itself, who we brought into that infrastructure too.

Q. Could we, please, have a look at INQ000083237.

Thank you.

So we're looking here -- yes, at page 2, we can see this is the HSSG planning and response structure chart. So at the top we can see the Minister for Health and Social Services. Beneath the minister we have you, your deputy Mr Heaney, the CMO, Chief Nursing Officer, chair of the Covid-19 planning and response group.

That's not the EDT contingency group we have already discussed, is it, because that came into place later, in October?

A. That was later, in October, but we had an internal EDT group which was also part of arrangements actually meeting more regularly than weekly, where it just allowed us to bring together some sense of the conversations that were obviously happening at speed in March. That was the core group that was invited but all of the directors were available if they were able to.

Q. I think you say in one of your witness statements you describe this as an informal group and you say "an informal summary or action points were taken by my office but not for the purposes of recording discussions or circulation". One might ask: well, what was the point of those informal summaries or action points?

A. That we were able to just share intelligence in a rapidly moving environment. Often those meetings were

taking place daily. We would revert to the weekly mechanism to make sure we're able to discharge those broader decision-making and, yes, there were notes of those meetings that were available if required.

Q. Below that informal group we have the Covid-19 planning and response group, and I think, as you've just said, the first meeting of that was on 20 February 2020, so that's some eight days before the first case in Wales --

A. Yes.

Q. -- of Covid. Do you think that was early enough for that group to have met or do you think that group should have met earlier?

A. I think that was early enough at the time in terms of how the virus was progressing. Through February, the overall UK assessment was -- was low, it changed to moderate at the end of February. At the beginning of February we were mobilising a whole series of mechanisms that were in line with our response plans, establishing the health desk, the emergency co-ordinating centre being established, the health countermeasures group, and all of those happened really in that first fortnight of February. At the time there was no Welsh case. I think, at the beginning of February, there had been a single English case, from a UK level. So we were mobilising and progressing, keeping an eye on the

progress of the virus, and all of these were pretty essential mechanisms that we were putting in place.

Q. We can see in the bottom of this diagram, reporting in to the HSSG planning and response group, we have seven subgroups in total. To the left of the group we can see the HSSG planning and response cell, which I understand, can you confirm, that was set up and established in March 2020; is that right?

A. That was March 2020, and was just really a subgroup of arrangements, so again it just took on a co-ordinating role. Again, some of the individuals, like Samia for example, were critical in that, but it was just a small group of people to make sure that the actions were followed through from all of the work that those different groups were doing.

Q. Again you say in, I think it's your personal witness statement, that:

"As well as establishing the HSS Planning and Response Group to bring system leaders closer to decision making in Government ... I established more frequent calls with system leaders to discuss pandemic preparation."

Just to be clear, reference to "system leaders", does that mean NHS chief executives?

A. Yes, NHS chief executives, although there were times

when there was a broader audience, so as an example chairs of health organisations tended to also join those meetings at least once a week, just for completeness and to be up to speed with all of the information.

Q. Now, from what we have been discussing and what we can see on the screen still, there seems to be an awful lot of different groups and different channels of communication. At the time, or indeed looking back now, do you think any of this could have been simplified or would it have benefitted from being simplified in any way?

A. I think the core of the planning and response group was really important. We needed to make sure we were able to bring together our own areas for action and attention from a health service and from a social care perspective, and that needed to be overseen irrespective of how Welsh Government oversaw its own structures. We were using as much as possible, however, some of our normal mechanisms, so chief executive calls across Wales on a weekly basis were a familiar mechanism that everybody knew, we just made them more frequent.

I think the seven subgroups were really essential to break up the individual areas, and I think what was really important in those, that it was bringing people with real expertise from our system into those areas to

advise on the policy that we needed to take forward. So the service voice and the frontline staff voice was embedded through these different mechanisms, so I would hold on to those particular issues.

I think the way in which we could improve some of these mechanisms would have, from my perspective, been trying to clarify some of the individual responsibilities. So there were probably some times in these individual groups -- if you can imagine, we're squashing everything about the NHS into categories, but the NHS on a daily basis is interfacing across many different areas, so I think some of the responsibilities could have been maybe clearer at the outset, and we were able to discharge that I think a bit later in our pandemic response as well. But I would broadly retain the planning and response group structures, I think they did serve us well.

Q. Perhaps we can just look at then a review that was carried out, I think it was a review from January to September 2020 and then there was a report dated 25 September 2020.

We've got it at INQ000083255. I'm grateful.

If we can have a look at page 3, so the HSSG Covid-19 response structure is set out here. Dr Goodall, you'll be glad to know I'm not going to ask

you to talk us through this diagram. If we can have a look at page 5, paragraph 1.2, just reading from para 1.2:

"The H&SSG whole system structure ... [Document read] ... into the overall planning and response structure."

So just going back to the question I asked a moment ago, do you think there were too many different groups or cells within the structure? Would you agree with what's said here, that there was a risk of a duplication of work?

A. I think the actual seven groups were focused on the right areas for us. I'd already highlighted myself that I felt in those early stages there were some areas where potentially there was duplic -- energy that was taking place in the early phase. It was a very fast-moving environment in the pandemic response at that time. Despite the reviews that we undertook, though, we retained the essence of the structure all the way through, so those seven subgroups were -- remained. What we tried to target was actually to make sure that people were really clear of their accountability and how they would interact with the different areas of responsibility as well, so -- but I accept that. I think in part I probably suggested some of that in my

answer just now.

Q. If we have a look, same document, please, page 13, I think it's the bottom bullet point under "Suggestions for improvement", it says there:

"The establishment of the NHS Executive ... [Document read] ... lead/support the system."

Can you just explain to us why that's something that was needed and whether it's something that has happened or is under way?

A. Yes, the NHS Executive was a formal programme for government objective. It was part of the manifesto that turned into the government programme. And it was a response to a parliamentary review that had been undertaken saying that we needed to put in an infrastructure for a guiding -- a guiding hand, an infrastructure for supporting the direction of the NHS in Wales. So that was in train at the time that the pandemic response came in. In many respects we stepped into that space because of the pandemic response, because the leadership was needed. The NHS Executive technically was deferred while we were going through the pandemic response, but it is now in place in terms of giving an additional level of support to the NHS Wales chief executive role.

Q. Just again staying on this document, I think it's this

page, in fact, paragraph 4.1 and looking at the fourth line, it reads:

"On occasions, there was lack of clarity on which areas were being led by [Welsh Government] or [Public Health Wales]."

Is that something that you recognise?

A. Yeah, I think in the early stages, as we were picking up in this very fast-moving environment, we would pick up issues and then be determining where the accountability needed to be in place for that. As the Welsh Government oversight mechanisms really initiated properly during March 2020, I thought that became a lot clearer, but there were at times some areas where we just simply needed to call out where the responsibility was. So as an example on the testing side, Test, Track, Protect was put in place with a director lead who oversaw the programme of testing responsibility from April 2020, and that was an alteration we needed to make just a give real clarity to the system.

Q. A second review was conducted by the HSSG, it was dated 11 October.

We've got that at INQ000083257.

We can see the first page there. If we could, please, go to page 5, and it's paragraph 6.2.3, and it reads there:

"It was not always clear as to where the ownership of decision-making should lie ... [Document read] ... HHSG structure fitted with wider Welsh Government ExCovid structure."

So this is now October 2021, which would suggest that the lack of clarity as to ownership of decision-making that had been identified back in September 2020 remained an issue over a year later; would you agree with that?

A. I think there was a constant need in our responses to make sure we were able to keep clarifying the lines of accountability. The Health and Social Services Group structures did feed, of course, into ExCovid, because that was through myself, but I think there was a very clear line of accountability about how the Health and Social Services Group fed into the 21-day review cycle which had been established and was in place very significantly throughout the months preceding this as well.

Q. You were obviously a member of ExCovid. Were the issues that are being identified here regarding decision-making in both HSSG reviews not something that ExCovid ought to have addressed?

A. They were reported up to ExCovid, so in fact the response I think that you're referring to here from

a Health and Social Services Group perspective, all of our own review mechanisms fed into ExCovid in terms of the lessons learned. But yes, of course, there was a need for us to separate in this the areas that were more operational responsibilities for the NHS as opposed to matters for government.

So if I could give one example of that with your permission, the operating framework for the NHS, which in part was guided by the views that colleagues were developing through here, they were matters that were for me to issue to the NHS in Wales in my NHS Wales chief executive role, they weren't necessarily matters that would be taken up by the wider Welsh Government body, for example.

Q. Another point that is raised in this, so sticking with this October 2021 review -- yes, it's same page, right at the top 6.2.1:

"Some HSSG decisions taken during COVID focused on minimising the immediate impact and harm. There is ... [Document read] ... of this short term decision-making."

Is this something that you agree with?

A. I recognise this because of the different phases that we went through, and it was really important that the harms framework that had been established by Welsh Government

during the first wave was used as a way of us understanding the wider impacts.

When we were making our initial decisions, not least on behalf of the NHS in that early phase, we were assuming probably a 13-week period of a pandemic response that we would work our way through would have some those immediate areas, but the balance would have worked to ensure that the NHS wasn't overwhelmed, for example. Over time, what we had to do was to make sure that we were balancing those wider impacts and some of those unintended consequences, so the restoration of NHS activity, for example, the way in which the lockdown decisions were overseen by ministers.

Q. Just before we leave structures and bodies, TAG and TAC were hosted, as I understand it, out of the HSSG. Did they therefore fall under your oversight as director general?

A. Yes, they did.

Q. Did you attend TAG and TAC?

A. No, they were professional meetings involving colleagues who were able to really focus on the evidence. But whilst it reported up and was a mechanism, I didn't attend it.

Q. How were the outputs of TAG and TAC used by you and your colleagues within the HSSG?

A. We had access to the evidence that they were producing, we were able to use that in our own reflections and tie it into our policy development. The paperwork and the documentation that was produced was issued as part of the Cabinet processes, so also we were able to give advice on that.

There was a later stage when, to support the Technical Advisory Group, we needed to oversee the range of areas that they were being asked to do, so later on deliberately we put in a mechanism as a steering group just to make sure that we could maybe make some judgements about the areas that they were looking at, because they were providing such good evidence that they were getting many requests from a range of different sources.

Q. I understand. And that steering group, that was yourself, Rob Orford, Fliss Bennee and Dr Atherton, and Reg Kilpatrick; is that right?

A. Indeed, yes.

Q. And you've touched on it already but what was the purpose of that TAC steering group?

A. There was such an intensity of work that TAC was undertaking. They were very embedded into the 21-day cycle review process, and ministers really highly relied on them. They were also acting to draw down

intelligence from a range of different sources. There was just the potential for moments where the needs of the week or the month ahead would be overtaken by the wide variety of areas. So it was simply a support and screening mechanism for them. I think importantly in helping them to discharge that function we always wanted, however, the members of the Technical Advisory Group to be able to follow evidence that was emerging as well, so obviously they still, at their discretion, were able to follow important pieces of evidence and advice.

Q. If we can turn next to your engagement with Welsh ministers, it's right, isn't it, that you were an attendee at Covid core group?

A. Yes, from the very start I was an attendee there.

Q. What was your role within that group?

A. The First Minister was really keen to make sure that there were appropriate updates around that table, right up to date, and my responsibility was really to give an oversight and update on the NHS preparations, the NHS response and the capacity areas. I would also have the opportunity to speak about care sector issues as well, depending on the discussion, the conversation that was taking place, but it was predominantly around the NHS position because of the way in which the virus was progressing.

Q. You also routinely attended Cabinet meetings; is that right?
A. Traditionally I wasn't a Cabinet attender, I would only go at request, but yes, during the pandemic response I was asked to be a regular attender at the Cabinet meetings.
Q. And from the minutes of Cabinet meetings that we've seen, it appears your role was essentially to brief ministers on key health and social care indicators, and then once the 21-day review cycle was established you would provide advice to ministers on capacity, resilience within the health system that would then inform their assessment as to whether to impose or lift certain NPIs; is that accurate?
A. Yes, that's correct. The predominant role when I was asked to contribute tended to be really about the NHS position, and often that would depend on the progress of the virus, but, yes, I was giving a very immediate update, including about how it felt in the NHS, not just on the data and on the evidence.
Q. I'm right in saying, aren't I, that you were not a decision-maker in Cabinet? I think you describe yourself in your evidence as a factual voice not a policy one. Is that right?
A. That's correct, yes.

Q. Now, as we've touched on, one of your roles was to understand and inform Welsh Government about capacity in the NHS. We've heard quite a lot about data collection from local health boards, how that was then analysed by the knowledge and analysis service, alongside Digital Health and Care Wales and also HSSG officials.

Would it be that data that you would be speaking to when addressing Cabinet?
A. Yes, there was data generally available. Of course we had had to create systems from the very start of the pandemic response, and I wanted to make sure that there was a consistency in the data and information that I was reporting on, but I would tend to give a sit rep report, a traffic light rating of the way in which organisations were responding around Wales, but yes I would use some core data particularly around hospital admissions and critical care admissions.
Q. I'll come back a bit later this morning to ask you a bit more about data and modelling, but in your view was capacity of the NHS and ensuring that it would not be overwhelmed, was that the main priority of the Welsh Government's decision-making throughout the pandemic?
A. It was certainly important during the first and second waves. I think the balance changed later on in the pandemic response, particularly when we had the benefits

of vaccination that was showing us that there was a different outlook for the virus. But making sure that the NHS was able to accommodate any Covid patients in the system, but equally to make sure that broader health services weren't overwhelmed so they couldn't discharge -- so that they were able to carry on discharging their essential roles was really important. So that protection of the NHS was really important in that early phase but particularly for the first wave and the second wave.
Q. And even in that first and second wave, do you consider that other factors, so such as the impact on the economy or the impact on mental health, do you think they were adequately balanced against NHS capacity?
A. I think the public health impact was certainly at the foremost of the Cabinet discussions, and I know for the First Minister personally. When the 21-day review cycle was established, it allowed us to ensure that all of the different respective voices were able to be brought around the table. So whilst I would update or be brought into a conversation, there were other areas that were highlighted around those discussions, again right through the pandemic response, and it was probably, I would say, through 2021 when it felt like the balance had changed and switched away from that more immediate

public health harm approach.
Q. Now, obviously you would be interacting with the Minister for Health and Social Services and the First Minister through Covid core group and also Cabinet meetings, but outside those formal structures can you give us a sense of your interaction with -- let's deal first with the First Minister. During the pandemic, how often would you brief the First Minister?
A. I would tend, particularly in the areas where things were very fast-moving, to be seeing the First Minister, you know, sometimes on a daily basis. There was a beat and a regularity about some of the more collective meetings that took place that would have just brought us into a general comment. I was available to him if needed. I hope in part it was a benefit that I'd actually worked in support of him when he was in his health minister role, so from a relationship perspective he would have known that he was able to access me for views wherever needed.
Q. What about the Minister for Health and Social Services?
A. That was a very regular contact, again depending on the intensity of the pandemic response and what phase we were at, but really would be a daily contact with the health minister about a range of different areas, not least on the data that told us about the progress of the

disease but actually on the things that we needed to put in place to support that as well.

Q. Now, we heard evidence yesterday about the production of ministerial advices. What role did you play, if any, in respect of the ministerial advices?

A. In my director general role I'm responsible for the oversight of the quality and to ensure that submissions go up. There would be some individual examples of ministerial advice where, given its nature, I would be more involved in it and would act to clear it. Most often the ministerial advice would be able to go up at a director level, even at a deputy director level sometimes, to ensure that the direct request was made to ministers as well. But I had to ensure that the process and the mechanism was in place.

Q. Can we now turn to the period January to March 2020 and I'll try to take my questions chronologically, so we start in January 2020.

We heard evidence in the Inquiry in Module 2 from Lord Simon Stevens, who was the chief executive NHS England during the period. His evidence was that he regularly attended COBR in February and March 2020. The Inquiry has also heard evidence from Sir Chris Wormald, permanent secretary of the Department of Health and Social Care, and again his

evidence was that he attended all COBR meetings in that period that were chaired by the Secretary of State for Health and then subsequent meetings when they were chaired by the Secretary of State for Health and then the Prime Minister.

As we've discussed, your role, your dual role aligned with their two roles in England. Did you attend or were you invited to attend COBR meetings in that period, January to February 2020?

A. Yeah, I wasn't directly invited. The First Minister or the minister attending would decide which official they would wish alongside them, but there was a constraint on attendance numbers, so, from a Welsh Government perspective, whilst it might have been helpful to attend, ultimately there was a limit on the numbers who could accompany the minister or the First Minister.

Q. And that was the same even when the COBR meetings became remote, was it?

A. So later, when the COBR meetings were extended, I was able to sit on -- at least on a couple of those to be able to listen in. That would allow me to give some advice to ministers and certainly pick up some of those issues outside. I found that personally very helpful to be part of that, because I was obviously leading, alongside others, the health response in Wales. So

I think probably if there was a way of sitting around that table it would be good to be there, but most importantly I think, the minister and the First Minister should be able to decide which officials join them in those types of settings.

Q. Was it your sense at the time that UK Government officials were privy then to more information than perhaps you were in January/February 2020, or is that not a position that you would take?

A. It's quite possible at a direct level. I of course, as you would expect, would have feedback from those COBR meetings on issues that were relevant at that time, but it's sometimes different, sitting in the room, hearing the presentations, and of course COBR has some limitations on the way in which information can be distributed, so I -- I was generally made aware of the outcomes. There were probably some examples, not least during February, where it would have been helpful to have had some of the information more directly for use.

Q. Were there meetings though between you and your counterparts in the UK Government to keep you sort of abreast of the situation that was developing in January and February?

A. We had generally good contact with officials in the Department of Health and Social Care, so from

an officials' perspective we were able to link, but some of the COBR oversight mechanisms were confidential and not for onward reporting, so it would tend to suppress some of the data that could be made available unfortunately.

From an officials' perspective though I found that those networks worked pretty effectively really but obviously they needed to progress themselves during January, February and March.

Q. In terms of your personal initial understanding in respect of Covid, you say in your personal witness statement that from around 28 January 2020 you were copied into daily briefings that were provided to the Minister for Health and Social Services and remained in close contact with Frank Atherton throughout that period. Now, you were, in fact, in a meeting of NHS Wales executive board on 21 January --

A. Yes.

Q. -- when Dr Atherton gave an update on coronavirus.

If we can, please, have the minutes of that meeting, it's INQ000262076, and if we could, please, have a look at page 3. I think it's the second paragraph.

It starts:

"FA ..."

So Frank Atherton -- yes, sorry, four lines in:

"[Frank Atherton] stated that colleagues need to think about their plans for isolation and ... [Document read] ... This area would become of increasing importance."

Did work on isolation begin at this stage, as recommended by the CMO? Just to remind you, this is 21 January 2020.

A. Work was initiated in terms of that advice there. Frank actually put advice more formally in writing at the beginning of February, so whilst this was a general update, when the position had moved from "very low" to "low" he made sure that that was dealt with more significantly, just to make sure that the system had that on record. But this was a chief executives meeting and an NHS executive board and I would have expected the chief executives would've gone away from that meeting and they would have been at that point starting to think about their business continuity plans.

Q. What was your main focus in January in respect of this new virus that you're hearing about?

A. I think keeping up with the intelligence on it, any understanding of it, and looking at the international progression of it. I think the assessment of the UK chief medical officers was really important in that respect, and in January it had shifted from "very low"

to "low", but we were starting to just try and have an understanding of the international outlook, so the introduction of the 28 January daily update was a really important part of giving wider information across Welsh Government. Whilst it was to the health minister it was widely copied to a range of ministers and different officials as well, and that actually allowed us to track not just the situation in the UK but it actually gave us a real feel of the international progress that was happening as well. But also at that stage we were really at the early stages of mobilising rather than pressing any particular buttons, because we were trying to assess when the translation into Wales and the UK would happen.

LADY HALLETT: Can I just go back -- sorry to interrupt -- go back to one of your answers, Dr Goodall.

A. Please.

LADY HALLETT: Forgive me for becoming cynical about some expressions, but as you know I've heard quite a lot of evidence about plans being work-initiating, developing, and you said "work was initiated". What do you mean? What happened?

A. Yeah, from a perspective of updating the chief executives, I think it was just simply that there would be awareness of this and doing it. From a practical

level, it was Frank's letter, I think it was of 5 February, that was actually putting in a formal requirement for the isolation and tracing, so from that perspective the formal ask into the system was there.

LADY HALLETT: So no work was initiated, you just became aware of the problem that might come; is that the answer?

A. I think there it was more awareness of it, definitely, at that stage and -- yes.

LADY HALLETT: It's just we need to be careful with the use of language. "Work was initiated" suggests that plans were put in place to do something as opposed to merely becoming aware.

A. No, if I go to the testing, the setting up of the testing units example, I think that's why it was very important that by early February Frank had actually that that place as a very formal ask from Welsh Government at that stage, so -- sorry, to clarify.

LADY HALLETT: Thank you.

MR POOLE: As we move into February, if we can have a look at a document INQ000320718.

This is, just to explain to you -- 13 February there's an email that you were sent by Reg Kilpatrick sharing the SAGE planning assumptions. These are those SAGE planning assumptions. If we can have a look at the

first row, we can see incubation period estimated 1-14 days, significantly longer than the pan flu reasonable worst-case scenario. If we have a look at the third row, the basic reproduction rate is estimated to be 2-3 in Wuhan. Fourth row, doubling rate in China was just 4-5 days. If we go to the seventh row, asymptomatic transmission could not be ruled out.

Now if we go over the page, please, to page 2, we see the first row there: 80% of the population could possibly be infected. Then, the fourth row on that page, 4% of the population could require hospitalisation.

So these planning assumptions were being given a couple of weeks after the first Covid case in England, which was 29 January, but at this point in Wales there had not been a case. That was to come later on, on 28 February. So Wales, it might be said, was in the unique position of having no confirmed cases at this stage but being privy to these planning assumptions. What steps were you taking at this stage prior to there being confirmation of a positive case in Wales?

A. This tied into a number of things that were going on in February. I think the day before this in particular had come in to us was the point where Frank had asked for the planning and response group to be set up and

established, and so we had put that in place at this time.

We had obviously, through our business continuity plans and our pandemic flu planning, looked at the range of areas that are set out on the left-hand side, so we had been highlighting, through weekly calls with chief executives, about the business continuity arrangements more generally, there were a range of areas that were put in place here, like the health desk and just stepping up the response, the emergency co-ordinating arena as well, all of which were fitting with what we would do.

From an NHS perspective we knew that there were difficulties that were based around the pandemic flu assumptions. But there were still some limitations on what we could share more generally with the NHS at this stage. So one of the constraints for us, and even marked at the top here, is about the ability to sort of forward this on in the system. We were having to translate that information but weren't able to be supported to widely share it with the NHS at that point.

I think a trigger point for us with the NHS response, irrespective of this having come in earlier, was when the reasonable worst-case scenarios were worked through at the beginning of March, and that allowed us

to more formally show the scenarios that the NHS needed to plan for and come to terms with as well.

So ... but at this stage obviously this was feeding in with some of the business continuity and business -- sorry, pandemic flu plan preparedness.

LADY HALLETT: I'm sorry to interrupt. Again, what did you do? Apart from set up groups, talk about business continuity with weekly calls, what did you do?

A. We were working our way through plans on this, but the NHS capacity plans were only really instigated at the beginning of March, my Lady.

LADY HALLETT: So you were working through weekly NHS capacity plans. What does that mean you were doing?

A. So during February, chief executives of health organisations had been asked to revisit their continuity plans, their capacity plans. There was some correspondence that was in the system that was asking them to get prepared at this early phase for a need for response. But what we weren't doing at that point was translating it into formal capacity plans for the NHS in Wales. That was something that took place in early March.

LADY HALLETT: Sorry to interrupt.

MR POOLE: The First Minister in his written evidence to this module has described that in January and February

Covid was not the top priority for the Welsh Government. Would it be fair to say that these planning assumptions were simply not taken seriously enough at this point in time, and it wasn't until you get into the early stage, the early weeks of March, that things really started to happen in Wales? Would that be fair?

A. Yeah, we were mobilising various actions at this time, but I agree with you that there was a change certainly in our response in Wales. That was in the last week of February, and certainly into early March. The Cabinet meeting that took place was a sign of that changing based on the COBR meetings that had taken place through February and the availability of those reasonable worst-case scenarios for us to plan for at the beginning of March was also a key point as well. So there was a change that happened at that point in terms of our response. And of course in early March we were also looking at the progress of the virus, you know, more internationally and there were some real concerns being expressed by the NHS in early March that we were again taking account of at that time.

Q. Just sticking with these planning assumptions, I think it was a point that I took you to on the previous page, on the first page, it was the seventh row where it said asymptomatic transmission not be ruled out. I mean,

does this show that by 13 February you had clear information, as it says there, that asymptomatic transmission could not be ruled out? Did that not set alarm bells ringing for the levels of infection control that would be needed in closed settings such as hospitals, such as care homes?

A. That wasn't necessarily triggered at that time based on that advice, but of course we needed to track the infection control and looking at the available knowledge and information as the virus progressed, but I don't recall it being triggered at that particular time.

Q. When did the risk of asymptomatic transmission first start to really factor into decision-making, can you recall that?

A. I remember, probably from an asymptomatic perspective, the focus of our early testing regime was on symptomatic individuals with some other priorities that were laid out, but it was -- probably midway through April was when it -- started to see that there was some emerging evidence that showed that asymptomatic transmission was a problem. Our approach and our testing was really focused on that symptomatic side, particularly during those very frenetic early weeks of the response.

Q. Just taking a step to one side, did you actively engage at this stage with the care sector to seek their views

on decisions that might need to be taken in response to the pandemic?

A. The planning and response cell had a social care subgroup, and that was the focus of our engagement with the care home system. It allowed us to understand their assessment of issues, also to raise any concerns and areas, often where they were seeking, of course, to know what the evidence and the support that would be made available to them was. So yes, there were mechanisms for that ability. And equally there was an opportunity for ministers to be engaged as well. But the planning and response cell was a good starting point, I think.

Q. The day after confirmation of the first case in Wales, so that was the 28th, so we're now talking about 29 February, you emailed Tracey Cooper of Public Health Wales and you said it "would be useful to just keep in touch on levels of contact and calls you were fielding given your enhanced arrangements", and then there was a response that she would keep you in touch and asked if it would help if she'd give you a daily status report, to which you responded:

"Yes that would help ... [Document read] ... a feel for public concerns and pressures on your teams and the system."

Just help us, what information were you seeking from

Public Health Wales at this stage, at the end of February, and did you get what you wanted?

A. Yeah, Public Health Wales had been very plugged in from January in terms of helping us with the understanding of the progress of the virus, and that carried on through February. It was very much tied into the updates that would go up to ministers. All I was really asking for from Tracey at that stage was I was aware of the intensity and the growing activity that they were undertaking in their tracing service and I just wanted to have some informal understanding from her about how that was going to give her some support for her team.

I'd visited the team as well to understand their response as well, and so it wasn't really about an alternative data source, it was more just checking in whether there was anything that was worth me knowing, because Tracey is an accountable officer and chief executives in Wales reported to me.

Q. As we move into March, I'd like to just show you a paragraph in your -- I think it's your personal witness statement, so it's INQ000396873, paragraph 303 -- thank you very much.

And I think this is in answer to a question I asked a moment ago. You've described this really as the trigger point. This is when you were discussing

reasonable worst-case scenarios, so you say:

"In March 2020, modelling for NHS Wales projected a necessity for 900 critical care and an additional 10,000 system-wide beds at the point of peak demand. It should be borne in mind that the existing capacity within NHS Wales was only 152 critical care and 7,839 system-wide beds as at the end of January 2020. This scenario was based on a 40% reasonable worst case scenario and, given the then rate of transfer, it was anticipated that Wales would see peaks in demand over the next 3-4 weeks. This reasonable worst case scenario modelling indicated that NHS Wales' capacity would be significantly exceeded, as over half the population of Wales would become symptomatic, with a high proportion of those contracting the virus requiring hospital care, including ventilation, and serious infection resulting in excess deaths."

My question is this, Dr Goodall: wasn't this obvious from the SAGE planning assumptions that we have just looked at in February?

A. I don't -- I don't think this was obvious at the time, and in respect of our pandemic flu plans and some of the experiences that we'd been through in both previous exercises but also in swine flu, we wanted to make sure that our response was proportionate, so whatever the ask

was and however the virus was progressing, that we were keeping in line with that.

I think it was significant that the first case in Wales was on the 28th and that acted in itself as a trigger. But the reasonable worst-case scenarios, there is a danger of seeing them as the forecast, that they are likely and that they will happen. In fact our swine flu experience told us different. You know, our reflections after that event was that we couldn't rely necessarily on the reasonable worst-case scenarios and go for it. I think the reality for us in March, though, was that the data that we were seeing progressed both internationally and on a UK basis was genuinely showing that the exponential growth and showing that the reasonable worst-case scenario was actually possible, and I think it was that realisation that of course changed the extent of our planning at that time.

There was a very different mood of the NHS system in early March, based on this exercise, but also based on the experiences that we were seeing internationally as well.

Q. I mean, leaving reasonable worst-case scenarios to one side, would you not agree that -- was it not clear by 29 January 2020, when the first cases were detected in the UK that the virus is now here, it's in the UK, and

in all likelihood there was no way of preventing it spreading to Wales?

A. I don't think that was obvious to us in all of the intensity of what we were going through at that time. We were making judgements based on those assessments, "very low" to "low", "low" to "moderate", and making -- to have judgements. In hindsight, of course that is the case, about wishing to have responded earlier, given the impact the virus had globally as well as of course in the UK, but at that time we were looking to progress in line with our planning, and seeing how we could respond to the assumptions as they emerged as well.

Q. At what stage do you say it became clear in Wales that if more action was no taken the NHS would simply be overwhelmed? Was it at this point in time, when you were carrying out these reasonable worst-case scenarios?

A. There was definitely a switch from the last week of February into that first week of March, and through a variety of different sources, including the contact with the NHS, where that felt suddenly very different and the need to step up those responses as well.

Q. If we could, please, have a look at some minutes, an ExCovid meeting of 10 March. It's INQ000320939. If we can -- thank you -- have a look at page 2, and it's paragraph 2.4.

I think we're picking it up in the fifth line, yes:

"Andrew Goodall added that if there is a change ... [Document read] ... likely to be those who stands to gain the most."

Was there thinking by this stage, so this is 10 March, that choices may need to be taken about which patients received critical care and which didn't?

A. It wasn't necessarily a choice at that time, but very much tied into this week were the planning arrangements for the stepping down of -- or the potential stepping down of actions and services in Wales, so routine activities, operations taking place, and that came to a culmination at the end of the week on 13 March. That in itself would mean that there would be a priority for emergency patients going into critical care rather than routine patients if we went down that decision.

However, in February 2022(sic), in the background of our arrangements, we had been updating extreme surge guidance just as part of emergency planning. It was updated again in April. Throughout the whole of the pandemic response we never had a need to introduce that emergency surge guidance, but it would have given criteria to services in Wales in the most difficult of circumstances to make choices, and that wasn't necessary at this time. But I think this was a reflection that we

were already in that week starting to ask the NHS what are the kind of things that would allow you to free up time to prepare, and I think this was probably a reflection of routine activities.

Q. I think you said February 2022 about updating extreme surge guidance. You obviously mean February 2020?

A. Sorry, February 2020, yes, thank you for that.

Q. Was there a discussion at this stage about who would take such decisions? Would this be an individual medical professional who is providing care to a patient, or was this a ministerial decision?

A. I think at this stage it was seen that it would be an area for individual clinicians, that's the strength of the NHS as a system, is to make the right decisions for patients. I think it was a recognition that there would be a requirement for us to put in place particular criteria. And I remember as an example, if I could just share it, that we had done some work through the Chief Nursing Officer in Wales just to make sure that criteria that may need to be used in critical care for nursing staff ratios, that they were owned by us nationally, so that there was support for what was going to be done on a local basis as well.

But there was definitely a need for us to recognise that, in the worst examples, we may need to step in with

that very kind of salutary and significant advice. Didn't feel that it was advice that ministers needed to direct but it was advice that ministers needed to be aware of.

Q. On 12 March you attended a meeting with the NHS Wales chief executives to discuss urgent action needed to be taken to protect the NHS. We've got an email from Tracey Cooper the same day, it's -- I'm grateful, it's already on the screen.

Helpfully, if you have a look at point 6 of that email, and particularly the third line, if I can pick it up from there:

"There is also a unanimous view from the COOs on the call that now is a compelling time -- both operationally and clinically on the basis of minimising exposure of current admitted patients in clinical settings to increasing COVID-19 patients, to free up capacity on elective, OPAs, discharging people, clarity around primary care services etc to enable people to rapidly implement capacity plans, prioritise clinical services and enable clinicians to prepare for what is to come which has apparently been an ask of anaesthetists and other clinicians in the system. The ask was for a decision to be made tomorrow (Friday) to proceed on this basis."

Did this email prompt you to start considering the framework of actions that was to follow or was this framework of actions that we'll come on in a minute something that was already in hand?

A. Yeah, it was already in train. We'd started, through conversations the previous week, we were observing some of the international area, the minister had actually asked for advice from the NHS on the weekend preceding this, I recall, just to allow us to understand what actions we could actually take. Health is a devolved responsibility and these were actions that we could take for ourselves at this time. And yes, chief executives were engaged, you know, with myself and others throughout the whole of this week working on a frame of actions and Tracey's email reflects that and gives a perspective on it.

Q. If we can, please, have a look -- so on 13 March I think you attended a press conference with the First Minister also the Minister for Health and Social Services to explain the actions -- it's a document the Inquiry's already seen, so it's a written statement by the Welsh Government. We can see page -- on that page, the first page, included measures such as the suspension of non-urgent outpatient and surgical care in Wales (that's the first point), point 4, expedite discharge of

vulnerable patients from acute and community hospitals, and then point 7, suspending the current protocol which gives the right to a choice of home.

Were these directions to be implemented as opposed to options, were these options?

A. These were directed nationally to assist the capacity requirements for the system. The delivery of them was a local matter. But yes, there was national direction on these, they were intended to give permission to the system to enable its preparations and to ensure that the NHS particularly was not going to be overwhelmed.

Q. Do you know whether an equality impact assessment was undertaken in respect of this framework?

A. An equality impact assessment wasn't taken at this phase. The speed and the exponential growth of the virus meant that we were stepping in very quickly. It was an unprecedented action that we were taking, and we were needing to discharge that responsibility very, very quickly.

There was a COBR meeting that had happened, I recall, on 12 March that the minister had gone to, and that really had made very clear that we would need to go alongside the NHS perspective and to put in place these arrangements.

Q. Was the care sector in Wales consulted on this

framework?

A. The care sector was consulted on the areas that were highlighted through the cell, and there was liaison on that. Of course that wasn't an engagement with the overall care sector but with representatives at this time.

Q. To what extent was it appreciated -- so, given the harm that could be caused to those suffering from illness other than Covid that required diagnosis, required prevention, required treatment, was it understood and appreciated at this time that this framework could in fact lead to excess deaths from non-Covid illnesses?

A. We had a real focus that whilst these were areas that we were stepping aside from to provide the preparation, we'd had very strong advice from the system about the maintenance of essential services in particular, and you may recall that we had an essential services cell within our planning and response arrangements as well. So these were not removing all of the responsibilities of the NHS, but they were allowing some choice around areas that were with more discretion. In winter pressures, for example, there's often decisions taken by health organisations to step away from some of the routine activities at the greatest area of pressure, and I think they were responsive to that. But we were trying to

make sure that there was still a focus on patients being able to access the system going forward.

Again, my Lady, the context here was that we were focusing on planning for a 13-week period of time. If we'd known that the pandemic was going to go on for two and a half years we may well have adjusted some of these decisions, but these were pretty essential to make sure that the NHS was going to be available.

MR POOLE: My Lady, we're not going to finish this topic, but that shouldn't stop us taking a break now.

LADY HALLETT: Certainly.

As you may remember, Dr Goodall, we take regular breaks. I shall return at 11.30.

(11.15 am)

(A short break)

(11.30 am)

LADY HALLETT: Mr Poole.

MR POOLE: Dr Goodall, we were talking about the framework of actions from 13 March, and the Inquiry understands that, broadly speaking, the chief executives of the NHS were in support of that framework of actions; is that right?

A. Yes, they had developed it through the course of that week and there were some further actions the following week also, which again had the NHS and system

sponsorship.
Q. You say in your evidence about the press conference announcing that framework of actions, you say:
"I recall that this press conference was very visible in Wales and caused some shock among the population."
Do you think it caused shock because the public were unaware perhaps up to this point in time just how serious the threat posed by Covid was in Wales?
A. I think it was a shock in part for that reason, although there was some sense in Wales that, in the context of the international experiences that we were seeing, we could see some parts of the population starting to act differently. I think the thing that stuck out for me, though, was that it was the first time that we had put the figures into the public domain about the likely impact in terms of what it would mean, not least deaths in Wales, and the health minister chose to do that as part of the press conference, felt it was really important that that was understood.
Q. Do you think this should have been something done earlier? Do you think it could have been better managed throughout February and March so it didn't come as such a shock on 13 March?
A. I think I'd go back to some of my earlier comments where

there are constraints on us about what can be reported, when and how. Things that come through the COBR mechanisms of course have a level of confidentiality around them. I think -- looking backwards, I think it would have helped to have been able to be more transparent with the population, certainly through March and maybe at the end of February, but at that time that was a judgement that the minister made at the time and I do think it was the right one.
Q. Now, that framework of actions we saw a moment ago, those ten points within that framework of actions, they were all within the competence of the Welsh Government, they were all devolved decisions to be taken independently of the UK Government, so the Welsh Government didn't have to wait for the first Covid case to come to Wales before taking those steps, nor did it have to wait for pandemic status to be announced by the WHO. I mean, generally speaking, had those steps been taken earlier, do you think they could have been undertaken in a safer way?
A. In hindsight I would say safer. They were themselves an extraordinary and unprecedented set of actions that we had never done before in the NHS, so from that perspective they were of really great significance. Looking backwards, they may have helped us to mobilise

and to understand some of those impacts in a different way, but at the time it was also to do something that was in line with the feeling and the evidence that was coming from the NHS itself, and it was really clear in that first week of March that the NHS felt that we were at a different position for planning and preparation.
Q. Now, one of those directions, I just want to focus on, which is expedite discharge of vulnerable patients from acute and community hospitals, now we know there was a lack of testing in the early stages of the pandemic and the Welsh Government then took decisions about prioritisation of testing, and we'll come on to that a bit later in your evidence. We also know that there was a period during which asymptomatic people were being discharged from hospitals into care homes without a test. Was this direction, to expedite the discharge of vulnerable patients from hospital, was that a ministerial decision?
A. That was a ministerial decision in line with the advice that had come up through the system. It was intended to do two things: it was intended to help the NHS to create capacity, because it would have meant that there were patients who were ready for discharge who could be cared for in alternative environments; but the wording of the actions as well was to try to provide support for

vulnerable people in those settings, because it was trying to move them to what we hoped was a safer environment.
It was inevitable that the hospitals were going to become the focal point for admissions and the growth of Covid, and we were looking to try to find a way of ensuring that those individuals were also supported as well. But first and foremost it was about how we created capacity for the Welsh NHS.
Q. Now, concerns seem to have been raised relatively quickly by the local health boards.
If we can see an email, it's INQ000262195, it's an email sent by your private secretary on 18 March. If we just focus in on point 1, please:
"Care home sector approaches to admissions -- Albert has taken up the concerns raised including ... [Document read] ... last Friday was about expedited discharge of vulnerable patients."
Again, a question I asked a moment ago: had the decision been taken to start expediting the discharge of vulnerable patients even a few weeks earlier, do you think that would have allowed for more safeguards? Would it have been appropriate to have put in more safeguards and ultimately save lives at this point in time?

A. At the time we were responding to the progress of the virus and the discussions with the NHS about supporting it to prepare. With everything that we know now about the pandemic response and looking back, that would have helped us, yes.

Q. You say in your statement, we don't need to have it up on screen, I'll just read the relevant extract, you say:

"At that time, we were not aware of the risks posed by asymptomatic transmission and, as testing capacity was limited, tests were prioritised for those who were symptomatic or who had been in close contact with those were symptomatic, including health and social care workers."

Now, as we saw from the SAGE planning assumptions from 13 February we looked at a moment ago, which said asymptomatic transmission cannot be ruled out, you also had the figures that were coming from the Diamond Princess cruise ship; you were aware of those, were you?

A. Yes, I remember from the reporting in the updates that we had at the time, yes.

Q. So by the time patients were being discharged from hospitals without tests, would you agree there was evidence that asymptomatic transmission was at the very least a possibility?

A. I didn't recall it -- I don't recall it standing out to me necessarily. Obviously I've revisited the February guidance at that time and colleagues would have been working their way through. What was important, as we were setting the expectations for the system, was to allow healthcare professionals, public health individuals, to give us the best advice and evidence that was available at that time, and throughout March and April, even with the changing guidance, it was the system and individuals trying to keep up with our knowledge at the time and the changes that were necessary.

So I -- it's difficult to respond to that directly, but we were always trying to spell out what was the latest guidance and evidence available to ourselves.

Q. If I can just show you, it's a 8 April document, it's a Public Health Wales document, guidance, as we see there, "Admission and Care of Residents during COVID-19 Incident in a Residential Care Setting in Wales".

If we can, please, have a look at page 3, I think it's the second paragraph, starting:

"The care sector ..."

If I pick it up fourth line it says:

"As part of the national effort, the care sector also plays a vital role in accepting patients as they

are discharged from hospital -- both because recuperation is better in non-acute settings, and because hospitals need to have enough beds to treat acutely sick patients. Residents may also be admitted to a care home from a home setting. Some of these patients may have COVID19, whether symptomatic or asymptomatic. All of these patients can be safely cared for in a care home if this guidance is followed."

Looking back, do you consider that this was sensible guidance? Care homes obviously are full of people who are particularly vulnerable to the disease, would common sense dictate keeping those who were infected away from such vulnerable people in care homes?

A. This clearly reflects the knowledge and the evidence at the time, and we would have some expectations for care homes to be able to accommodate isolation procedures. I think this document itself later spells out actually how isolation mechanisms and procedures would work, as you go through the rest of the document as well.

In retrospect, and in hindsight, given what we know now about the asymptomatic, yes of course that could have been targeted differently. One of my own worries for the hospital systems were they were likely to be areas where patients were likely to be exposed to

Covid-19, so there was something about trying to ensure that we could find the safest environment for patients who were in our system, rather than just leave people within the hospital environment as well.

But, yes, with the knowledge that we have now, we may well have changed some of these issues at the time.

Q. Changing topic, if I may, and talk a bit more, as I said I would earlier, about data and modelling. If we can perhaps just have a look, first of all -- it's a TAC advice of 20 March.

We can see it at INQ000083241.

If we could have a look at paragraph 4 of that TAC advice, it says:

"TAC strongly advises ... [Document read] ...

"ii COVID Hospitalisations."

Then if we could have a look at the next paragraph, paragraph 5, please:

"TAC recommends ... [Document read] ... at 3pm each day."

Was this TAC advice actioned? Was this something that was taken forwards and happened?

A. As I recall it, it happened. I know that some of the operational data, not least from some of the health boards at the time, was difficult, so there were some issues of consistency as we all started to gather some

of these reporting arrangements.

It was really helpful that we had our knowledge and analytical service that was able to act as the quality guardian for some of that data.

From a public perspective the data for the NHS in Wales I think was made available in the third week of April, where we started to actually put some of the data that we'd been using within government more into the public domain, so not least for transparency it was also important.

Having said that, I should say that the press conferences that were being undertaken by ministers, including by myself, we were talking through some of the information that was available and up to speed with and we were following through with that information in the public domain as well.

Q. If we could just have a look, and sticking with this TAC advice, at page 4, please. It's the second bullet point on that page. Yes:

"As of 20/03 there has not been a complete set of accurate data from all Health Boards that describes both ICU or Hospitalisations from COVID-19."

I think, picking up on your previous answer --

A. Yeah.

Q. -- something you say in your statement on behalf of the

HSSG -- I'll just read it to you, we don't need it displayed, you say:

"So, at the outbreak of the pandemic in March 2020 there was no system that captured a real time (daily) national picture of total beds and occupancy ... Having said that, was the picture at a national level there were local systems to capture capacity and occupancy. However, these were inconsistent and varied in ambition, accuracy and output."

Why had that not been addressed before March 2020? Is that not something that could have usefully been done in late January and February?

A. I think there were different data systems in place for our organisations. Some of these were new areas that we were highlighting beyond even some of the operational data as well.

Obviously we were tracking and testing for the first time, it was something that was different and needed that reassurance. I can't answer in a level of detail why that wasn't, but I do know that some of the health organisations were struggling with some of the definitions and advice and we were supporting them to make sure that they could turn that into a proper and accurate data.

In my own experience we were able to actually use

the general data available, even if at times in those early phases it wasn't perfect, because they allowed us to track the surveillance and the progress of the virus, so I wouldn't have wanted that sort of approach to make sure it was all fully accurate to stop us from our tracking that was in place.

LADY HALLETT: Wouldn't you need a complete set of accurate data from all health boards in normal circumstance?

A. In this respect, we were adding in new areas, of course, for the tracking, but at a national level --

LADY HALLETT: No, no, in normal circumstances.

A. In normal circumstances at a national level, we do have a sense of the range of the operational data in the system, but we don't have all of the system information available at the national level all of the time. A lot of that is dealt with by local health boards in respect of their own operational responsibilities. So we don't always pull this information into our national setting on a daily basis.

There is some information, like bed occupancy for example, or A&E attendances, that I was able, in my role, to track on a daily basis, but there were some limitations to some of that data as well, my Lady.

LADY HALLETT: Don't you think in the future there ought to be that data available for a person in your role?

A. In the future I think having access to that operational data -- and we were very quickly able to put that in place for the NHS, so it was a -- matters of days and weeks when we had a system that I felt was robust and appropriate.

LADY HALLETT: So that is now in operation?

A. We have got --

LADY HALLETT: And has lasted since the pandemic?

A. Yeah, we have retained the systems that we put in place and they are available, and should there be another pandemic, we have learned so much from this one that they would be available into the future as well.

LADY HALLETT: Thank you.

A. It became part of our routine, my Lady.

MR POOLE: Returning to a document that we looked at earlier, which was the review of the HSSG response -- it's INQ000083255, thank you -- if we can have a look at page 7, paragraph 1.9, it says -- yes, right at the top of the page:

"Data availability and reporting took some time to be ... [Document read] ... via the PHW Coronavirus Data Dashboard."

Just help us, what's meant by hospital transmission data?

A. Yeah, it's the nosocomial transmission data. So

transmission that is happening across areas within a hospital environment. So it's not the hospital admission data, for example, it's not discharge data, but it would be an understanding to be able to track whether there were outbreaks in a hospital environment. So organisations had local systems but it was only really in the summer that we were able to have a proper understanding of that under the kind of definitions and clinical criteria that were in place.

Q. Why was that not available to the NHS until, as it says here, late July/early August?

A. It was a limitation from some of the extant reporting systems and we obviously were putting in a wide variety of new requests and new information systems in place at the time. That would have been, of course, helpful and important for us to have earlier.

Q. Did that not massively put you on the back foot?

A. It meant that hospitals were having to use other measures to try to track those types of issues. We had outbreak mechanisms and we had local infection control teams who were able to draw the actions and responses together but, certainly from a national perspective, it was the first time we were able to report that on a national basis.

Q. I want to change topic now, please, Dr Goodall, and ask

you a few questions about shielding.

On 19 March 2020 you emailed Mr Gething explaining that there was a problem ensuring that there was an accurate database of vulnerable people. Presumably that was to identify who was to receive a shielding letter; is that right?

A. Yes, that's correct.

Q. Can you briefly outline what was the problem and how was that problem resolved?

A. There was Chief Medical Officer discussions that had taken place about wanting to ensure that there was support around vulnerability and for particular groups, through clinical criteria, and trying to reconcile different databases that were in place. So the chief medical officers had put a request into the system to identify ways in which we could come up with a list of patients.

Every system, England, Scotland, Northern Ireland or Wales, has a different way in which they align their databases. It was an extraordinarily technical and complex task, as I recall, and I was needing to advise the minister that it was more difficult to operate in practice for all of us across the UK, but we were ensuring that we were able to address it as quickly as possible at that time.

There were conversations about announcements being made about shielding, and I think it reflected an approach where we rather would understand the situation, make the policy decision, and then we knew that we were able to practically implement, and what we were doing at that stage was working through the practicalities.

But I don't think an exercise like that had ever been done in reconciling data across many different health systems.

Q. A point that you made in your email to Mr Gething was that the English system had access to a national prescribing database that's able to support the data run, which you point out we don't, Wales doesn't, have the equivalent. Have systems been put in place since that would ensure the system is smoother in the event of a future pandemic?

A. Yes, so we have commissioned national prescribing systems for Wales now through a national investment as well.

I should say that when we were doing the shielding advice, though, one advantage of the data we eventually produced was that it meant that individual clinicians didn't need to validate them individually. There was quite a lot of effort required in England for hospital

and -- consultants and GPs to actually spend time reviewing those. By the end of March, Northern Ireland and Scotland were asking us how we had been able to pull together that database, so I do feel that in very short order we had managed to address those issues and actually come out with a very robust database.

Q. Different topic, if I may, about disproportionate impact. When did it become clear to you that those from black, Asian and minority ethnic backgrounds working in the healthcare sector were being disproportionately impacted by the pandemic?

A. We had seen it emerge more generally in April with some of the national reporting. I was mindful at the time that England at that point was ahead of Wales on the progression of the virus, but from a system perspective it was really a discussion I recall, I think, around the -- the Cabinet table where it occurred, but it was a letter from Professor Singhal that highlighted to us particular concerns, not least how this impact was affecting healthcare workers.

So Professor Singhal was asking health boards to put in place risk assessments and approaches that would be supportive, obviously had written to myself as part of that process and there had been some engagement very directly with the First Minister of Wales by

representatives of ethnic minorities in Wales.
Q. Now, I think that letter from Professor Singhal, that's a letter of 17 April.
A. Correct.
Q. We heard something about it in the first week of evidence. There was also a letter from Race Council Cymru at about the similar time.
You explain in your witness statement that it was 1 May that you endorsed the use of an existing risk assessment tool developed by the Aneurin Bevan University Health Board as an immediate way forward. We obviously heard evidence, the Inquiry heard evidence, last week from Professor Ogbonna that there was work being carried out in respect of a risk assessment tool that was then presented in late May, and I think it was then rolled out on 27 May.
I mean, do you have any comment on the fact the Aneurin Bevan health board had managed to create its own risk assessment tool in April and yet the Welsh Government's commissioned risk assessment tool wasn't finalised until 27 May?
A. I think what I wanted to do at the time was to make sure that the group, who were a group of experts that we drew together, had urgent but sufficient time to do the work. The reason for my intervention on 1 May was that I gave

a national direction to all of the health organisations to start using that risk assessment. One of our advantages in Wales is that we could pick up these local templates and try to use them to expedite.
So there was a delay but that was a reason why I wanted to make sure that the risk assessment was generally available. I do think the work that Professor Singhal and his colleagues did was really exemplary in an urgent context. Its use has been very significant, not just for the NHS and care system in Wales but beyond, and I think ending up with probably about 130,000 uses of the individual risk assessment, you know, and it stayed very similar to that initial version, has been really important to the pandemic response all the way through, and gave confidence.
Q. Change topic again and ask some questions about PPE, please.
If we could have on screen INQ000303227. This is a WhatsApp group you were in with Shan Morgan, Dame Shan Morgan, Andrew Slade, Tracey Burke. If we can go to page 5, right down at the bottom of that page there's an email -- sorry, there's a WhatsApp. It's 20 March. This is from you, just read it:
"Probably worth reflecting on still a public discussion on Ppe -- shortages and who to use and

access. As an aside sos announcing Ppe is available for all social care is different from our position -- we have issued PPe from pandemic stocks to supplement local supply to be everywhere in wales by Monday geographically distributed -- our calculations are that there are finite supplies for the weeks ahead that if we don't have some order in use, would without replenishment at uk level run out -- so we need to ensure that thresholds for use are maintained.
"The process feels more and more like announcing a concept and working back ASAP in detail and practicalities -- this reflects the speed of events has meant that some of the spirit of sharing has been disappearing so we are finding it happening less simply on speed of decision making and announcements."
So this is 20 March, did you have concerns that there may come a point in time at which PPE would simply run out in Wales?
A. Generally that was a concern. We reported as such in the public domain as well. I even recall a press conference where I was asked about supplies that were left, and I think I very openly said that we were within a few days of some individual items at the time. That was later in April.
I think the pandemic stocks that we'd put in place

as a contingency allowed us to manoeuvre our way through those first weeks with around 10 million items that had been made available. But absolutely, we needed to ensure that there was a good supply chain in order and we were able to achieve that.
My role was really to secure that supply at a national level, but what we also had to do is very much change the way in which we were issuing supplies across Wales, literally to thousands of sites, rather than the few hundred that would have been the reality for the NHS in Wales.
Q. Now, PPE was something that was raised by the BMA Cymru on 22 March 2020.
INQ000118526, if we could have that, thank you very much.
So this is an email, in fact a response to an email that you had sent about shielding. However, as we can see under the heading at the top, "PPE", the BMA say that before they list their comments on the shielding letter they must raise the issue of clarity on PPE guidance for GPs and other doctors/healthcare professionals. So if we're looking at the second paragraph, second line:
"Whilst I do not feel a public dispute on this would be helpful in Wales, we ... [Document read] ... in line

with the WHO guidance and latest research ..."

So there's a clear suggestion there from the BMA that PPE was not being supplied and guidance not being given in line with WHO guidance. Is that something you agree with?

A. That's not how I recall it. We were always really clear about being in line with the WHO guidance. We had healthcare professionals who were working on that advice, but actually this was an area where the UK networks and the frameworks that were in place really helped us, because that guidance was worked through clinically and collectively across the whole of the UK, not just ourselves.

I think it was quite right, however, for the BMA to be insisting on that requirement. This wasn't just an exchange that I had, I'd had a number of contacts with the BMA over those two weeks or so and it was really important that they were, you know, looking for confidence and reassurance.

I hope that one thing that we did do later that helped with that was that we put PPE supplies very much in the public domain, and one thing earlier that I, again, had authorised with chief executives was to make sure that locally in their own organisations they were able to show their staff about the level of supplies

that were actually available, because of the underlying worries that obviously healthcare workers had at the time.

Q. Did you think there was an unreasonable expectation upon the HSSG to co-ordinate allocations and guidance for PPE in this period, so in March 2020?

A. I think the health-led aspects absolutely fitted. We had a strength around our NHS shared service arrangements, that gave us the supply line for Wales that meant we could do that with confidence, even if we were expanding at scale very, very quickly.

I think where PPE became a matter of other sectors, that'd become more problematic for us to handle and deal with, because we were so intensively involved in the health response that access to PPE for other professions was an issue.

Having said that, to Shared Services credit -- the NHS Wales Shared Services, they were actually able to extend some of the supplies beyond just health and social care to some other areas as well.

Q. Do you think PPE is an area where there should have been quicker cross-government co-ordination to assist the HSSG, for example?

A. I think if we look at the outcomes that we achieved in Wales, building on from pandemic preparedness and

supplies right through to using the NHS Wales Shared Services, I think it was right that we were left to discharge those arrangements. We obviously needed ministerial support, I think we could have had some broader support for some of the other sectors in Wales -- sort of mindful on the Audit Wales review that was done, when they went in and looked at what we'd done. They gave a positive review of the way in which we'd stepped up in Wales and provided that response, certainly through a health and social care setting, but some assistance on maybe some of those broader sectors would have been one of the things that may have helped in retrospect. But I think we were really very focused on the health and care response.

Q. Move now to some questions about testing. In your personal statement to the Inquiry, you say:

"... throughout March and April 2020, the Welsh testing programme was significantly constrained by the availability of both antigen and antibody tests."

You go on to say:

"Early testing capacity was clearly an issue, and while Public Health Wales took early action to commence contact tracing and stepped up their gold command arrangements to discharge their first responder function, they were impaired initially by a lack of

available tests."

Then perhaps we can have the next paragraphs of your statements, 332, you can see that on screen:

"In hindsight, if testing capacity had been available, I believe that despite the extraordinary ask it would have represented, maintaining a universal contact tracing system may have more positively affected outcomes over the subsequent weeks of the pandemic. Of course this was revisited and reintroduced later through our Test, Trace, Protect mechanisms, but the decision-making and progress was significantly affected by insufficient testing capacity. Ultimately, our laboratory capacity across the UK did not have the infrastructure in place to rapidly expand; subsequent decisions we made to expand and invest in capacity highlight this weakness in our response arrangements."

At what stage, Dr Goodall, did it become clear that there was a limited testing capacity in Wales?

A. I think it was almost immediately clear, because we needed the first test to be available, and of course, as we were looking to track from a surveillance perspective the virus, it became very clear in those immediate weeks about some of those limitations. We didn't have the laboratory structure available, as I've said in there.

Maybe to give a comparison about the early phase, if

I can. We had 1,800 tests a day available in mid-March. If you compare it with the testing regime that was taking place when Omicron variant was around, we were up to 200,000 tests a week. And that is a very different position in respect of the testing capacity that we had in place.

Q. Who decided who should be prioritised for testing?

A. We took advice there. So, as you would expect, it was done from a healthcare professional perspective, in particular in these early weeks. We had advice and support from Public Health Wales; it was part of the expertise that they held, but it was also relevant to their first responder status as well.

Q. If we could please have a look at an email chain between Albert Heaney and the office of the Deputy Minister for Health and Social Services. We've got it up in front of you, if we could go to page 2, please.

This is on 22 March, email from Lee Waters, he says:

"I've been contacted by a care home ... [Document read] ... Not sure who to direct this to for advice?"

Then Mr Heaney replies, it's up the email chain, at the first page, he says:

"Thank you ... I understand the importance of this matter ... [Document read] ... discussed with sector leads."

Then he sets out those four bullet points that we can see on the screen.

Now, it would appear that despite real concerns being raised by care homes, that the Welsh Government were continuing to push for discharge of patients despite knowing there was a lack of testing. Would you agree with that?

A. It was based on the knowledge and evidence that we had at the time, and we needed to ensure that the overall health and care system was able to maintain patient flow throughout it, because what happens at the front door of a hospital very much is linked to what happens at the discharge end. So you do need numbers of patients to be discharged out of a hospital environment on a daily basis.

Q. In your letter to Shan Morgan of 13 May -- we don't need to bring it up on display -- you acknowledge difficulties with testing capacity and you acknowledge that the minister had promised an expected step-up in testing capacity to 5,000 tests a day, which ultimately the Welsh Government was not able to deliver.

I mean, in the future, what steps could be taken to ensure that the system is simply better equipped to respond to the potential need for mass testing?

A. I think the learning from the pandemic response, the

retention of infrastructure. I think, my Lady, maybe one of the areas that we've not touched on today is what do you hold on to in respect of contingency and redundancy. The NHS always runs very hot just in terms of its daily activities, and I think an understanding that there are expectations and requirements that we must hold ready for an environment like this in the system.

It's difficult because you have to fund it and you have to have it available. But one advantage to us in Wales is that we have retained that laboratory facility that we undertook during the pandemic response.

Q. We move forward in the chronology to August 2020. I want to show you a letter that Dr Atherton wrote to you on 10 August.

Now, I think I'm right in saying, as the first paragraph would suggest, this was written at your invitation, so you were in fact inviting him to set out his concerns to you; is that right?

A. Yes, indeed, I think I recall that we'd met at the end of the preceding week, so ...

Q. If we could have a look at the second paragraph, so the letter's outlining "significant concerns about our ability to manage the next phase of the pandemic in Wales", and amongst those concerns, if we have a look,

please, at paragraph 3 are -- it's:

"[The] TTP programme has been one important reactive element and is now functional but ... [Document read] ... to staff regional responses."

Then if we can have a look at the same page but paragraph 5, I think it's the last paragraph:

"Public Health Wales has proved itself adept at managing community outbreaks and ... [Document read] ... control using the health protection funding we provided last year."

Then if we can, please, go over the page to page 2, Dr Atherton here references, I think it's about six lines up from the bottom of that first paragraph, he references new functions of the Welsh Government that the permanent secretary expects to be resourced from within HSSG, and he welcomes an urgent discussion with you.

Then the last paragraph on page 2, please, Dr Atherton talks about the fragility of staff and says that much work has been unseen and underappreciated by the wider organisation.

So, first of all, were these all concerns that you appreciated at the time and perhaps shared at the time?

A. Well, firstly I would say in respect of, you know, a lot of the work, I saw it and I appreciated it, and I think

it's really important to say that here, in terms of the way that teams and colleagues stepped up to respond to the pandemic.

I do recall and register this. I know I wanted Frank to be able to say very clearly to me what he thought next steps should be, and I think there are two things that I would respond, with your permission.

Firstly we had actions in train with Public Health Wales. As Frank rightly said, the ability to use some of the health protection funding, but we were also investing in laboratory systems as well.

I think we did approach vaccination differently with our national programme, and resource it, and make sure that was in place.

But the real concern I think for Frank in August was did we have internal recognition of the need for more staff for the Health and Social Services Group. We were a small group of 400 colleagues carrying out these functions. I was able to reassure Frank that a business case had already been provisionally agreed at the end of July, but actually the resourcing meetings that were taking place in August did agree a transfer of significant staff for us to carry out these functions, so we had an additional 70 staff allocated to us through August and September of that year as well. But it was

clearly recognising the need for us to know that there was a second wave coming and to make sure that our overall infrastructure was going to be appropriate for that.

Q. The firebreak, as we know, came into force in Wales on 23 October. In your view, was that the right time for the firebreak?

A. As I recall the firebreak -- firstly, I supported the firebreak, I thought it was essential. I was mindful of it being advice via SAGE. We were testing other mechanisms to give some support to localities through September in particular, with locality approaches. And always mindful of the proportionate nature of the response. If there were geographical areas in Wales with no virus and no examples of it having an impact on their communities, taking a national action could be quite significant for them. So I think seeing whether those local areas worked or not was really important.

Having said that, the firebreak was a really important intervention. It was more limited than maybe ministers had wanted from their discussions around the table, but I do think the firebreak had the impact that was broadly intended because it reset the virus by about 38 days.

Q. Should it have been longer in your view, from an NHS

perspective?

A. There was definitely support from the NHS for a firebreak to take place, and during the firebreak, because the NHS was always seeing the figures three or four weeks after the decisions that had been taken, we were seeing our data show that more patients were coming into the system at that time.

I think a longer firebreak would have been preferable, but there were genuinely funding limitations from a Welsh Government perspective and ministers of course were very mindful of the wider harms that needed to be determined outside of the NHS itself.

Q. You provided an update to ExCovid on 6 October. We don't need to have it displayed, I'll just read from those minutes:

"On hospital admissions for Covid-19, these are at 550, double on that of a fortnight ago. These are not yet at the level seen in March and April but the infection rate needs to stabilise within the next 2 to 4 weeks or we will see hospitalisations exceed the figures from earlier in the year."

By the time of the next ExCovid meeting, 13 October -- if we can see those minutes, please, INQ000221045 -- if we can have a look, please, at page 2, paragraph 2.1, your update here was that:

"There [were] just over 700 patients in hospital with Covid-19, this is a 50% increase in the last 7 days."

And then in paragraph 2.3:

"NHS plans to deal with an increase ... [Document read] ... increase, then the chance of patients, visitors or staff taking the virus into hospitals also increases."

Finally, paragraph 2.4:

"If the number of hospital admissions for Covid-19 ... [Document read] ... to the numbers seen in the spring."

So just a few questions arising from those minutes: were you pushing for those measures from 6 October, when you were aware of the worrying statistic about hospital admissions that had doubled in just two weeks?

A. I was sharing from a factual perspective the information about the NHS, whilst the NHS wasn't seeing numbers that were like the peak that we'd seen in April. You can see from the two examples that you've given how it was clear that there was exponential growth happening, for that 50% increase over a seven-day period was really important, so I wanted to make sure that there was an understanding of what that meant.

NHS capacity was available to accommodate those

patients, but there was an outstanding discussion about what we wanted to do with the NHS. Was it to keep providing its general responses or were we looking to just stop the virus completely? And I think I was highlighting that in some of the discussion too. This information was all fed into the Cabinet process that was reviewing the firebreak, of course, as you would expect.

Q. Do you think the Welsh Government took this information seriously enough? Do you think they acted too slowly?

A. I think it was taken seriously. I was minded by this time there was a regularity with the 21-day cycles. You know, ministers did have to make decisions that were broader than just the NHS. Any time I was presenting the NHS information it was always taken seriously, but there were other things that ministers need to think around the table, whether it was TAC advice or whether it was some other wider harms at this point, and there were certainly concerns about whether a lockdown being repeated would lead to examples like school closures again, for example, and they were featuring quite strongly around ministerial discussions.

Q. Now, hospital-based outbreaks, so nosocomial transmission, something that will be covered in much more detail in a later module, but at a very high level,

would it be fair to say that there was no firm grip on controlling hospital outbreaks by late October 2020?

A. I think there were very clear infection control guidelines and practicalities in place. As you would expect, the NHS would have really strong infection control, and with expertise in this area. The real struggle was that as community rates increased you would see rates increase in hospitals inevitably because they would translate across, and we saw that right through the whole of the pandemic response.

So if I could set out that there was a clear framework for infection control but the reality of the virus was much more difficult to handle on the ground.

Q. Is this something that was avoidable, though, in your view? Should steps have been taken sooner? Should this have been appreciated going into the autumn of 2020?

A. I think without a mechanism for having staff in the highest level of PPE at all times as if they were in a theatre or critical care environment, which is obviously the most supportive and prevents transmission, we were making sure that we were in line with all of the World Health Organisation codes and actually in line with the UK guidance at this point as well.

The real difficulty is the way in which Covid-19 found ways of working its way into any system.

I remember Frank in his Chief Medical Officer role often talking to me about how the virus was always looking for the weaknesses unfortunately, despite all of the preparation and all of the best efforts. I think that was a reality of experience for us throughout the pandemic response.

MR POOLE: Dr Goodall, those are all the questions I've got for you, but there are some questions from the core participants, I think.

LADY HALLETT: Yes, Ms Harris.

Questions from MS HARRIS

MS HARRIS: Good morning, my Lady.

Good morning, bore da.

A. Bore da, good morning.

Q. I appear on behalf of Covid-19 Bereaved Families for Justice Cymru. I would like to ask you some questions about PPE workstreams, and specifically with regards to the Covid-19 health countermeasures group, which you've referred to in your evidence as having the role of operational co-ordination and oversight of the Welsh Government's pandemic health countermeasures for PPE, consumables and medicines, and that the group monitored distribution arrangements as well as identified and resolved issues associated with supply.

Before I get to the question, if I could highlight

some points in the evidence. First of all, the evidence provided by Mr David Goulding that he chaired this group and that the first meeting of the group was on 12 February 2020, and I'd like to ask for this document, please, to be produced up: INQ000298968, which is an email dated 20 February, if that could come up on screen.

Thank you.

That is an email noting the action points arising out of that first meeting of the group on 12 February 2020, and if I could take you to some of those action points, for example, first of all, action 2:

"GD to provide a list of the six PPE products required for Coronavirus."

Action 3:

"DG to raise at the Clinical Countermeasures Board Coronavirus sub group the absence of long cuff gloves, visors and fluid resistant gowns in the stockpile."

Action 4:

"HEPU to ascertain whether a [just in case]/[just in time] contract exists for the order of soap."

If we could go to the next page and to action 10:

"HEPU to clarify the relevant items in the Wales pandemic stockpile and communicate that information to

NHS EP leads."

At action 11 there's a reference to ascertaining whether there are people trained to fit test.

And if we go to action 15, a number of individuals are allocated "to discuss a concept of operations".

And we see there are 20 action points all in all.

When considering the question I'd like to ask you about timing, I'd invite you to have in mind the landscape as it was in January 2020, because this group of course started to meet on 12 February 2020.

In January 2020 we had, first of all, 16 January, that the virus was given the initial classification of HCID, high-consequence infectious disease.

We know that Public Health Wales had evoked its emergency response plan at enhanced level by 22 January.

On 24 January or by that time we know that the Chief Medical Officer for Wales had advised the First Minister that there was a significant risk that the virus would arrive in Wales.

On 30 January the World Health Organisation had declared a public health emergency of international concern.

On the 31st it was made public that two patients, they were related to each other, had tested positive for Covid in the UK, and we also know that there had been

attendance at two COBR meetings.

And on 29 January, at that COBR meeting, the UK Chief Medical Officer had said that the reasonable worst-case scenario for the virus was similar to that for pandemic influenza, which of course, as we know, signified widespread infection and many thousands of excess deaths on that scenario.

So my question is: do you agree that it was obvious from the very early stage that if the virus arrived in Wales, PPE supplies were bound to be needed and quite possibly very quickly and in large quantities? And given that, do you agree -- if you agree with that proposition, do you also agree that the work that the countermeasures group was doing should have started at the very earliest opportunity and earlier than 12 February 2020?

A. From my perspective, in Wales, the introduction of the health countermeasures group was an early intervention. As I was describing earlier, the assessment at that stage and through February was that this was low impact at that time for the UK, and that drove a lot of our triggers and actions at that point.

The health countermeasures group wasn't starting with a blank sheet of paper. The advantage that the health countermeasures group had was that it already had

availability of up to 10 million PPE items which we had in storage. I think that note rightfully shows that there were areas of operational detail that needed to be worked through, and there was an urgency around doing that at the time.

Pandemic flu preparation was different to some extent from some of the PPE that was required for Covid-19, and I would have expected those gaps to happen. But at the time I felt it was in line with a low impact assessment that at the time there was no evidence of it for Wales.

If I was describing -- given the two and a half years that we went through later and the opportunity to set in train some of these things earlier, then that would have helped at that time, but I don't think it actually changed the nature of the way in which we distributed from the pandemic stock, for example. So that was always available to us to be secured and provided for the different sectors.

Q. Can I just ask you, do you think it was correct to regard the situation as a low impact assessment at that time?

A. It was the Chief Medical Officer's assessment, and we would be putting in place our actions in response in line with that at the time. So I'm responding to how it

felt at the time and how we were responding. Of course the pandemic itself was an extraordinary impact on all of us in society over an extended period of time, and that was very different from how we would have been approaching those early days in respect of using our emergency preparedness.

Q. So you wouldn't accept that there would have been any benefit from having started this work of co-ordination and oversight and the kind of actions set out in that email at an earlier stage?

A. I think -- given what we know now, I think that would have been helpful to have worked through, but I do think that the way in which we were securing those supplies, working our way through those choices, meant that we were able to secure that national supply for Wales, even if it was under very extreme pressure at times as well.

So I'm not sure it really changed the outcomes at that stage but was part of that early planning and preparation.

Q. Can I ask you about a comment that appears in the witness statement of Mr Vaughan Gething where he says, and I'm reading a passage from page 138 of his witness statement for this module:

"We underestimated how quickly the PPE ... [Document read] ... amount of our stockpile was not fit for

purpose."

If I could ask you: does the fact, as I assume you would agree is correct, that a certain part of the stockpile turned out not to be fit for purpose, do you agree that underlines the need for very early active steps to look at availability of supplies of PPE?

A. It also goes to the point I was making earlier just about contingency and levels, I agree. I agree with the minister's comments, the way in which the virus then progressed subsequently, despite the fact that we had 13 weeks of supply that was technically available in the pandemic stock, that ran down much quicker than we were expecting, but we were able to pursue both through UK level arrangements and through our own local supply chain a way of maintaining that national supply to be in place.

LADY HALLETT: I think you need to go on to one of the next two questions, Ms Harris, I'm afraid. That was a very long introduction to your first question.

MS HARRIS: It was indeed, thank you.

LADY HALLETT: Most of it wasn't allowed.

MS HARRIS: Thank you.

I'd like to ask you about social care, and we know that, and may I take Dr Goodall very briefly to the document in relation to this, and I do appreciate that

I need to be quick.

It is a document at INQ000252549, if that could be pulled up, please. Thank you.

This is a written statement by Mr Vaughan Gething, "Distribution of ... (PPE) to social care settings", and it's on 19 March, second paragraph:

"I am aware of the concerns ... [Document read] ... PPE."

And at the fourth paragraph goes on to say:

"If PPE stock cannot be accessed ... [Document read] ... if a case of Covid-19 has been confirmed."

Is it right that that was the first substantial help that was given to social care in relation to PPE and up until then they had been left largely to fend for themselves?

A. I can't -- I can't really recall -- I can't recall the run-up to this, but this was reflecting our advice and actions and interventions. I know that on 9 March we had introduced arrangements to make sure we were able to put additional supplies into GPs right across Wales, and we were working our way through how we would want to respond.

Of course individual care homes would have had a level of PPE supplies supported by their local authorities at the time. What this was triggering,

I think, really importantly, is that we were going to ensure that we stepped into the difficulties of PPE supply for social care, and we over time expanded that very significantly. Out of 2 billion items that we provided across Wales in the whole of the pandemic response, about 800 million were provided to care homes, so about a third of the overall response, and that felt appropriate.

Q. But this was --

LADY HALLETT: I'm afraid you'll have to finish there.

MS HARRIS: Thank you, my Lady.

LADY HALLETT: Sorry.

Ms Foubister.

Questions from MS FOUBISTER

MS FOUBISTER: Thank you, my Lady.

Good morning, Dr Goodall, I represent John's Campaign and Care Rights UK.

I'd like to refer first to your statement of 29 September 2023, which is the one dealing with the Health and Social Services Group.

That's INQ000319643.

When we get there, I'm going to go to your page 71, paragraph 242.

You note here that you wrote to NHS bodies on 5 May 2020 identifying action that should be taken to

ensure cancer services provision, including to put in place support systems to deal with concerns from cancer patients regarding social isolation and shielding.

Why did you raise a concern specific to cancer services?

A. At that time as we were tracking the virus -- I think I'd also written out in April and some work had been done by our cancer network in Wales -- we were concerned that the data we were receiving was showing that with the lockdown arrangements in place the numbers of cancer patients accessing services had reduced. So that is patient who are concerned about cancer rather than diagnosed with cancer. And it was just very visible to us in our very early data that we needed to do something more about that. We wanted to make sure that essential services were available for the NHS, even though we had stood down some very individual services across Wales, and cancer was one of those services, not uniquely so.

Q. I think some of that data you refer to is at the next document I was going to turn to, which is INQ000300217.

This, when we get there, is an impact assessment document from later on, from November 2020, and I'm going to go to page 20, the first sentence, and also there's a diagram which we should be able to see at the bottom of the page.

So are you aware, as it states here, that the number of cancer patients on the NHS wait list increased 8.9-fold from the beginning of March to 12 June 2020?
A. Yes, I did, I was tracking the data because it was an area of concern, yeah.
Q. What was the response to your letter of 5 May, the one I referred you to a moment ago?
A. We were overseeing these arrangements through our essential services group, that local organisations were looking to see how they could recover some of that activity. The Cancer Network in Wales was really helpful in giving support to local organisations but there was always a balance that, whatever the national framework that was in place, organisations needed to bring patients back in safely, so the operational delivery of that was very much with local health boards as organisations.
Q. Were your concerns around this taken into account by decision-makers?
A. I do think that they were taken into account because we were very clear that we needed to maintain a focus on accessing services. But these were numbers as that as your data was showing was a worry, because they were deteriorating. One of our worries were that people, if they weren't accessing the services now, we would end up

with them coming later in their pathway experience and we just wanted to make sure we could intervene as soon as possible, despite how much of the virus was around and about us at the time.
Q. So you refer to data on the cancer services, were you aware about serious concerns being raised about the adverse impact of isolation on people with other health conditions such as dementia or Alzheimer's?
A. I was aware of that, I think the TAC report that you've pulled up actually reflects on that itself in respect of some of those broader impacts, not least on the shielding, irrespective of the impact of lockdowns as well.

We obviously had to focus on those broader harms as we progressed more so through wave 2 into wave 3 of the pandemic response, and we did include reference to those areas within our quarterly operating frameworks that were issued from the NHS.
Q. Did you write any equivalent letter to your May letter drawing attention to those concerns for these other health conditions and asking for specific action in relation to those?
A. I didn't. There was something very specific about cancer that we saw on the data that we were monitoring. Within our operating frameworks that I was issuing

quarterly we were describing these broader areas and the importance of making sure that whenever activity could be recovered that it should be done so.
MS FOUBISTER: Thank you.

Thank you, my Lady.
LADY HALLETT: Thank you very much, Ms Foubister.

I think that completes the questioning for Dr Goodall.
MR POOLE: It does, my Lady, yes.
LADY HALLETT: Thank you very much for your help so far, Dr Goodall. I'm sorry, I can't give you a guarantee that it won't be the last time. I know that you've helped me before in another module and this one, and it may be we'll call on you again, but thank you very much for your help.
THE WITNESS: Okay, thank you very much. Diolch yn fawr iawn.

(The witness withdrew)
LADY HALLETT: Ms Jung.
MS JUNG: My Lady, the next witness is Dr Tracey Cooper.

DR TRACEY COOPER (affirmed)

Questions from COUNSEL TO THE INQUIRY
LADY HALLETT: I'm sorry if we've kept you waiting, I'm afraid we're not going to finish you before we have to break for lunch.

THE WITNESS: Not at all, my Lady.
MS JUNG: Dr Cooper, thank you very much for coming today to assist the Inquiry. Can you start by giving the Inquiry your full name, please.
A. Tracey Ann Cooper.
Q. Is it right that you have produced two witness statements in this module?
A. That's correct.
Q. The first is at INQ000235212. That is a corporate statement produced in response to a Rule 9 request sent to Public Health Wales.
A. That's correct.
Q. The second is at INQ000276282. That is a witness statement produced in your personal capacity.
A. That's correct.
Q. Are the contents of both of those witness statements true to the best of your knowledge and belief?
A. They are.
Q. Is it right that you also provided a witness statement which was the personal witness statement in Module 1? That is at INQ000195849.
A. That's true.
Q. And in Module 1 there was a corporate witness statement on behalf of Public Health Wales, but that was signed by Dr Quentin Sandifer, and that is at INQ000192266.

A. That's correct.
Q. Did you have input into that statement?
A. I did, yes.
Q. Are both of those statements for Module 1 true to the best of your knowledge and belief?
A. They are.
Q. Thank you.

Moving on to your professional background and role, Dr Cooper, is it right that you are the chief executive of Public Health Wales and that you have been in that role since June 2014?
A. That's correct.
Q. You qualified with a bachelor of medicine from Southampton University in 1990?
A. That's right.
Q. Prior to your appointment as chief executive of Public Health Wales, you worked as the inaugural chief executive of the Health Information and Quality Authority in the Republic of Ireland between August 2006 and May 2014?
A. That's correct.
Q. Before that, you were the deputy head director of operations for the NHS Clinical Governance Support Team, Modernisation Agency, Department of Health England between January 2004 and August 2006?

A. That's correct.
Q. You also have experience of working internationally, including with the World Health Organisation?
A. That's correct.
Q. The International Association of National Public Health Institutes?
A. Yep.
Q. And the International Society for Quality in Health Care, of which you were a board member from 2008 to 2015, and president between 2011 and 2013?
A. I was, yes.
Q. I want to ask you next about the role of Public Health Wales and a bit about its background.
A. Yes, so Public Health Wales was established in 2009 and it was part of the health structural reforms in Wales at that time. It was established under a statutory instrument with four main statutory functions. And perhaps if I can summarise them, they are to deliver health protection, microbiology and screening services, to provide health improvement programmes, to undertake data analysis to survey the health of the population, and to undertake research and evaluation about the health of the people of Wales.
Q. Thank you. And is it right that Public Health Wales is the national public health agency in Wales?

A. That's correct, yeah.
Q. It's also an NHS Trust?
A. It is, yes.
Q. And it's also a Category 1 responder for the purposes of the Civil Contingencies Act?
A. It is.
Q. And therefore plays a key role in relation to the preparation for and response to emergencies and major incidents, which includes pandemics?
A. Yes.
Q. Moving on to the role of Public Health Wales in response to the Covid-19 pandemic, please.

In the corporate statement you say that Public Health Wales mounted an unprecedented response to the pandemic, which was part of a Welsh system-wide effort to respond effectively to the challenges faced as the pandemic progressed; is that right?
A. That's right, yeah.
Q. Could you please provide a brief summary of what Public Health Wales' role was in response to the pandemic, please.
A. Of course. So early on in the pandemic when, which I'm sure we'll come on to, we could see what was coming down the line, we mobilised the organisation to the point that by 24 February we'd already made the decision that

Covid response was going to be a single priority of the organisation.

So we mobilised the organisation and then we scaled up core functions and activities that were relevant to protecting the public, particularly around our microbiology diagnostic functions, our health protection functions, our population surveillance functions.

We also provided a broad range of technical and professional expertise and advice to the Welsh Government, guidance to partners. We undertook tracking of the course of the virus, and its impact on the population, which changed and evolved through the various phases of the pandemic. And we also undertook research and evaluation not only in relation to the impact of the infectious nature of coronavirus but also the impact it had on the wider socioeconomic health harms.
Q. Thank you.

Can I ask you about some matters that weren't covered in that very helpful explanation. What was Public Health Wales' role in contact tracing?
A. So, as is normal for public health practice for any public health body, contact tracing is a standard health protection response where there is a health -- an infectious disease incident. And so that's normal,

that's normal place for us, it's something that we have always done. As in the early days, in January/February, heading into the beginning of March, we were the sole organisation at that point undertaking contact tracing, mainly, initially, for people who were coming back into the country, returning travellers. As the geographic case definition increased, there were more people who were coming back into the country.

So we early on, around about end of January, we established a contact tracing cell, which means other -- in a normal small incident it would just be a number of our team. When we establish a cell it's because we need to have an expanded group of experts to respond to, and expanded activity.

And so, through the course of February and March, our teams -- we just were pouring more and more staff into the national contact tracing cell, tracing over 100 contacts that were coming in. And so that -- and at the time we were the sole organisation doing that contact tracing.

Q. What about in relation to quarantine of the people that you were tracing?

A. Yes, so part of that, the conversation was about -- was giving people information and advice around self-isolation. So anyone who was -- had returned from

a high-risk country or anyone who was a potential contact of a potential case or a case, the standard advice would be given around isolating for a period of time, ten days and then 14 days it moved on to, and the active tracking then of any contacts they had come into contact with before that point. And of course we weren't in a position to physically go out and check whether people were actually doing what the advice was.

Q. Did you have any role in relation to ports and borders?

A. We did. So the Welsh Government asked us advice over the first couple of months, particularly around about June, in my recollection, as there were discussions happening, I understand, from a UK Government perspective, around what does international travel look like, and what further prohibitions needed to be put in place. So we established a port and borders cell.

That activity then expanded as restrictions were brought into international travel, and we became an organisation that received the data from the Home Office around returning travellers and would contact individuals, give them tailored advice. That operation then changed over the time of the pandemic and I think, January '21, Cardiff Council then took over the function of receiving that data and then liaising with returning travellers.

Q. Is it fair to say that the role and responsibilities of Public Health Wales during the pandemic were very broad ranging? Were the roles and responsibilities always clear to you throughout and as between Public Health Wales, the Welsh Government and other responders?

A. I think that was a challenge. That was a challenge I would say in the first year. When we worked with colleagues across Wales to develop the health protection response plan, which was submitted to the Welsh Government on 12(?) May, that is a comprehensive plan that really clearly articulates the respective roles and responsibilities of the different players who were really important, including local authorities, health boards, ourselves, Welsh Government, also colleagues in third sector and others. I think from that point onwards, it was much easier, and clearer.

Up until that point, we did find ourselves on occasion, as many national public health bodies did, we know working beyond our skillset or our mandate, and some of that was because that was no pre-existing organisation or entity doing an action that was needed and so, you know, we were stepping in to try and help.

Q. Is an example of where Public Health Wales acted outside of scope in relation to establishment of the National Contact Centre in February 2020?

A. It is. We, again, as a normal core function for health protection for us we have an out-of-hours, an in-hours system that we -- a process that we call AWARe, which is notification of any health protection emergency. So we've always had a facility that allows partners to contact us for advice, but that's really more about incident by incident.

What we found very early on as we went through January and particularly into early February is that we were having more and more contacts of professionals and individuals seeking advice, not just because they had members of staff or members of the services they were providing needing support, but they were concerned about what was happening. So we brought some of our team together, initially with a handful of staff, and that very, very rapidly grew into setting up a National Contact Centre. And the function of that primarily was to provide advice, and we extended the hours through to about 8 am to about 10 pm, I think was the peak for us, to professionals, managers, for people from schools, from care homes, from care facilities, from businesses. So that was the purpose of the National Contact Centre.

Q. Thank you.

Just before we break for lunch, are there any other examples of where Public Health Wales acted outside of

scope during the pandemic?
A. There are. So around about 1 April in 2020, one of my team was contacted by Deloittes, company. Deloittes had been commissioned by UK Government to help establish mass population sampling centres, and we'd been informed that a mass population sampling centre -- so where multiples of the population can go through, have the swabs done, a little bit like a normal process experience -- and one such mass centre had been established at Cardiff City Stadium.

Unfortunately neither ourselves or the Welsh Government knew about that. And so literally over the course of about four or five days the team developed standard operating procedures, worked through the process, the end-to-end process, and I think by 7 April we were up and running, delivering it. The reason being that it was there and of course we couldn't not use it, but it hadn't been planned. So we ran that for about 60 days. The team did amazingly, actually, and we then handed that over safely to Cardiff University health board.

Meanwhile, Deloittes were really helpful. We subsequently then worked with them closely in setting up other large population sampling centres, together with the local authorities and health boards. So that was

an area that we wouldn't have expected, ourselves, to do.
Q. Just to give us an idea of the strain on your resources, what was the capacity of staff working in the National Contact Centre and in that mass sampling centre?
A. Well, in the National Contact Centre we -- I think the peak we had at maximum was about 800 calls a day. And that waxed and waned through different phases of the pandemic and then we were able to transfer that into a different, much more reduced contact centre. But when we were establishing that, very literally overnight, we took over half of our -- fourth floor of an office. We then rolled it into Swansea and we rolled it into North Wales so that we could have some resilience. And our IT team ensured that, later on, we could -- people could be call handlers from -- working from home.

But it required the development of new processes, new training, a new governing model. And so we had, if I recall, through shifts, probably about 30, 40 people working at National Contact Centre.

In relation to the sampling centre, it -- on 18 March, unfortunately we had to make the decision to suspend our -- the majority of our national screening services, with the minister's approval, because of going into the delay phase and the impact that had, whilst we

maintained some of those screening services. So quite a lot of our screening team were able to mobilise into the sampling centre but nevertheless I think at any given time running that we probably had about 20 people, and then others that were involved across the organisation in different elements of that end-to-end process.
MS JUNG: Thank you.

My Lady, would that be a convenient time to break?
LADY HALLETT: Certainly.

Just one question. Did I hear you correctly that somebody decided to set up a mass population sampling centre in Cardiff without telling the Government of Wales or Public Health Wales?
A. Indeed, my Lady.
LADY HALLETT: Right.
A. It turned out --
LADY HALLETT: Do we know who that was?
A. -- to be helpful. I don't know.
MS JUNG: Was it Deloitte?
A. I think it was part of -- well, Deloitte had been asked to set it up. I think it was part of the intention to create that -- the mass sampling, obviously the swab, and the mass testing across the UK. I don't know who made the decision though.

MS JUNG: Thank you.
LADY HALLETT: Extraordinary.

Right, I shall return at 1.45.
(12.45 pm)

(The short adjournment)

(1.45 pm)
LADY HALLETT: Ms Jung.
MS JUNG: Thank you, my Lady.

Dr Cooper, I'd like to explore with you next the different ways in which Public Health Wales provided advice to the Welsh Government during the pandemic.

Can we start, please, by confirming that Public Health Wales did not take part in any informal or private communications such as WhatsApp groups with ministers or senior servants that informed significant decision-making --
A. No.
Q. -- and as such doesn't hold any records?
A. No.
Q. You say that in the context of Covid-19 the requests for advice from the government increased significantly. When did that increase happen, was it gradually over the whole time, or did it ramp up after a certain time?
A. I would say from around about middle of February, it started to, to increase. We were already providing

information through our engagement predominantly with the Chief Medical Officer at that point, and our teams were attending daily incident management teams with the rest of the UK counterparts, so there was situational awareness, information coming through that we were sharing but really from probably the second half of February, and then from early March it really rose exponentially.

Q. Thank you.

Can I ask you about advice notes, please. You say in your statement that the first formal advice note to the Welsh Government was on 12 October 2020. How was advice provided by Public Health Wales prior to that, so in the period between January 2020 and October 2020?

A. So we were continuing to provide multiple pieces of advice between that time, and the reason perhaps to differentiate this from 12 October is that was the first time we put in place a process that was more systematic with Welsh Government, because there were so many requests coming in that we wanted to create something that was more of a definitive position.

So prior to that we were asked for advice from different policy leads around sampling, testing, infection prevention and control, the provision of -- the requests for those advice came through emails, they

came -- we were asked to provide advice during meetings. One particular example is when the Chief Medical Officer wrote to me on 22 April asking us to develop the health protection response plan, which obviously was a plan that we put forward, and our information back took the guise of advice that my team may give during meetings through to us putting documented advice in where requested, where it would be a briefing note or it would be an advice note that pre-dated, if you like, the new model that we were doing from October.

So that didn't mean we didn't provide advice before October, we provided a multiplicity of advice. It was just the system was more refined when we got to October.

Q. Thank you. Could I ask you to slow down just a little bit --

A. Sorry. Sorry.

Q. -- so that the transcriber can keep up. Thank you.

So is it fair to say that in the period up to October 2020 there were multiple requests from multiple contacts on multiple topics, and is it fair to say that a record would not have been kept of all of those requests and of all of the advice provided by Public Health Wales --

A. Not in a --

Q. -- in that initial period?

A. And that was one of the reasons why we moved to the October model. Not in a systematised, tracked way -- obviously every individual has got the records and we've pulled a lot together for the Inquiry, but as far as a registered approach going forward, that was one of the learning points for us, that we really needed that to happen and to elevate the level of advice that we were giving in the way that we were imparting it.

Q. So is it fair to say that Public Health Wales does not have a comprehensive record of all of the advice it provided during the pandemic?

A. Not -- not from the beginning, and really from October onwards.

Q. And would you accept that that initial period was a crucial period in the pandemic?

A. Yes, it was a very crucial period.

Q. Can I ask you, please, about your contact with ministers. In your corporate statement, you say that the advice provided to the Welsh Government by Public Health Wales appeared to be well received, and that you understood that the advice was incorporated into the decision-making process. Are you able to say with any certainty what advice was accepted or rejected or what weight the government placed on certain pieces of advice?

A. It's a really good question. I think on occasion we could because we could triangulate it back to the advice that we were giving. So, for example, I mentioned the Public Health Protection Response Plan. That became the operational model for what was then published on 13 May, which was Test, Trace, Protect strategy. So we could see the derivative of that from the advice that we'd given.

We knew that particularly when we were -- got into that more formative advice process from October, we knew that TAG was including our advice either as copied and pasted into advice or as an appendix into the advice they were providing to Cabinet, particularly around looking at consideration of NPIs, restrictions, that -- really from that autumn point onwards. However, to -- we weren't able to track every single piece of advice, and whether or not that was taken on. Obviously we were one part of the advice suite that ministers were considering in order to make decisions, so they would weigh up other elements that -- so to varying degrees, would include ours, I would have anticipated.

Q. Is it right to say that in those forums it would be a case of Public Health Wales being one of a number of people providing advice and then the decision being made at a later date in a different place?

A. Yes, and really typical examples of that is when we -- when Wales went into the local restriction time, the First Minister would convene a group of the respective leaders, chief executives for local authorities, chairs and chief execs of health boards and other key partners, in considering what the situational awareness was in order to consider going into a local lockdown. The decision wasn't made at the meeting; we would provide advice, but the decision was made after the meeting. So it was predominantly more of a multi-agency approach, yes.

Q. In Module 2A, Professor Nick Phin gave evidence, he was director of public health services for Public Health Scotland in January 2021, but at the start of the pandemic he was deputy director of the national infection service within Public Health England, and so from his experience of working within both those organisations he was able to provide some interesting perspectives about the way in which things were approached differently in those two nations.

With regard to Public Health Scotland, what he said was that there were minimal opportunities to provide ministers with a first-hand account of the thoughts of senior staff in Public Health Scotland, or to make them aware of the practical implications of policy decisions.

He said the main mechanism by which Public Health Scotland was able to provide advice to Scottish Government was through the National Incident Management Team.

Is that similar to what happened with Public Health Wales?

A. No, I would say we were -- whilst we didn't make the decisions, obviously Welsh Government ministers made the decisions, we worked very closely with them. So I, all the way through, obviously was working, as my team was, very closely with the Chief Medical Officer, and so the Chief Medical Officer was obviously able to share at direct hand any comments into ministers, similarly with Andrew Goodall as director general.

But we also attended a considerable number of meetings with ministers and we've shared in the statement some of the key ones, but there are others, where we were able to give -- share our thoughts on what the latest evidence was, not only for Wales but other countries.

There were also specific periods where, for example, we had a number of outbreaks in food and meat production factories where ministers would set -- there were a number of meetings where there were a number of ministers attending those meetings, and other partners,

where, again at first-hand, we were able to share the information.

And from about October in 2020, myself and my chair reverted to what was happening pre-Covid, where we would have normally around about bi-monthly meetings with the minister for health -- as Public Health Wales and the minister for health with the director general or the Chief Medical Officer. So we were able by the time we got to October to revert back to those, which was helpful because we could give a -- quite a specific element of our views, but also increasingly the broader harm impact of Covid.

Q. Professor Phin said that in relation to Public Health England, that he was involved in face-to-face discussions with ministers, he was in the room providing direct advice, advising on what introducing policy could mean on the ground, what the relevant issues were that had to be thought through, and he said he thought being in the same room advising and pointing out the implications was really important. Do you agree with that?

A. Absolutely.

Q. And you say that Public Health Wales did have that direct line to ministers?

A. We did, certainly up until that -- that -- the Christmas

time, I would say, or before September, the majority of those occasions were with others, and we would share information in advance. So we may be asked for briefing notes for the Chief Medical Officer or the director general to share, but I think one pivotal moment was on 19 December 2020 when two of my team were asked to join Cabinet meeting to give direct advice. And obviously we were in the Kent variant phase at that point, and we'd preceded that by issuing a number of advice notes, and so Dr Chris Williams, who you met last week, and Catherine Moore, one of our senior clinical scientists, virologists, who submitted a Rule 9 statement, attended that meeting directly with the Cabinet to give that first-hand advice. So I wouldn't say there was a time where we -- when we were in that position, we were invited to understand.

Similarly in August 2020 the First Minister invited us to attend a Cabinet meeting, myself and one of my former directors, director of policy and international health, to share the international learning that was happening. Unfortunately there were technology problems so we couldn't do the direct engagement with them, but that was -- it makes such a difference to be in the room, yes.

Q. Is it fair to say that there were specific occasions

where you did have direct meetings with ministers, but was that direct line always open throughout the pandemic?

A. Well --

Q. Can I work through an example?

A. Yes, please do.

Q. So Professor Nick Phin said that in Scotland there was a situation where the government had decided that they should be checking up on people to make sure that they were maintaining quarantine and that that led to a reasonably robust exchange between the chief executive of Public Health Scotland and the Scottish Government, where Public Health Scotland were saying it just wasn't a feasible option.

Am I right in understanding that something similar happened in Wales, where Dr Sandifer says that he received an email from the Welsh Government on 31 May 2020 with an expectation that Public Health Wales would write to all overseas travellers by recorded delivery letter, followed by telephone contact for monitoring, and he had to write back pointing out the difficulties with that. First of all, Public Health Wales could not access the passenger locator form database held by the Home Office; and, secondly, did not have the operational requirements to be able to send out

150 recorded delivery letters a day followed by daily phone calls, 14 days for each arrival.

Is that the kind of misunderstanding that could have been avoided if ministers had been in the room with Dr Sandifer or others leading the response?

A. Well, that's a really good example, and perhaps you can clarify with Dr Sandifer tomorrow, but my recollection, if I recall correctly, is that Quentin, Dr Sandifer, was invited to a discussion with the First Minister on this precise issue, and expressed the logistical challenges of it. And again, I think please check with Dr -- with Quentin tomorrow, but I think we were saying we didn't have a problem in doing it, but actually the process was too cumbersome and not realistic, that we would prefer to do it by email in a safe, information-governed way. And I understand that the First Minister accepted that.

Q. Thank you.

I want to move on, please, to multi-agency meetings that Public Health Wales was involved in, starting with meetings with the Chief Medical Officer for Wales, and I'm going to try to deal with these broadly chronologically from when they were established.

So you say that informal catch-up meetings happened with the Chief Medical Officer for Wales, starting from 26 January 2020. What did you mean by informal catch-up

meetings?

A. So these really took the nature of a quick half hour, what we were learning internationally, what were the concerns we had, where was Wales at. No decisions were made at those meetings, and they were very similar to what we'd have done pre-Covid in quite a relaxed catch-up way. And on occasion the Chief Medical Officer may ask us to provide advice to him on X, but they were not -- they weren't formal structured agenda -- we wouldn't share an agenda, it was very much a rapid situational -- sit rep, if you like.

Q. Bearing in mind that Public Health Wales got its first briefing through Public Health England on 8 January, do you think that those meetings with the Chief Medical Officer should have started earlier?

A. Well, my understanding, and again Quentin is closer to this than me, so in -- my understanding is that, and I think the first meeting with Public Health England was the 7th, we issued a briefing to the NHS on the 8th, and then again on the 10th.

But the team, under the auspices of Quentin, were already very close in communications with the first -- with the Chief Medical Officer, so it wasn't that no engagement happened, it was the fact that we, from 26 January, we start -- we just scheduled into the

diary, whether we needed them or not, a quick half hour situational report.

Prior to that there was just constant engagement between the team, the Chief Medical Officer and officers working in the Chief Medical Officer's office, so really from that point in time we were -- we were working in synchrony with him.

Q. Albeit these were quick half-hour sessions, were they recorded?

A. No.

Q. Do you think they should have been recorded?

A. I think if we were to run this again, just having a tracker -- as I say, there was no agenda beforehand and there weren't decisions made, that's not the purpose, and they were happening so quickly, but I do think it's helpful to have a tracker, even if it's just "these are areas we discussed and Public Health Wales was requested to do X". The situation was happening so, so quickly, but I think that's an important learning point.

Q. Can I ask you about the Public Health Wales, Welsh Government, Wales Ambulance Service s NHS Trust meetings. So these were daily informal catch-ups, is this right, starting on 28 January 2020 up until 3 March 2020?

A. As far as I'm aware. I wasn't directly involved in

them, but yes, as far as I'm aware.
Q. Do you know what the purpose of those meetings were?
A. Yes, I think it was very much, we worked very closely, as Category 1 responders, and Welsh Ambulance service trust is a key responder, so when we're into an incident we engage with them regularly, and at that time -- it was at the beginning of that time Covid was deemed to be a high-consequence infectious disease, and so the transportation for the ambulance service of patients who are, who have a -- potential or have a high-consequence infectious disease is significant for them logistically. So my understanding is those meetings were set up originally to work through with them how they would go about undertaking that transport, and then of course subsequently it was de-designated as a high-consequence infection, and so they fell away and the next phase of the pandemic kicked in, if you like.
Q. Albeit Covid-19 was designated formally as a high-consequence infectious disease, is it right that from the very outset it was at least out of an abundance of caution treated as if it was?
A. Yes.
Q. Bearing that in mind, do you think that the meetings with the ambulance trust should have happened earlier, to warn them about potential cases coming in?

A. We were briefing the ambulance trust as with the rest of the NHS, so when we sent the briefing out on the 8th and the 10th, we sent it out to the NHS, and that's all of the organisations.
So again, whilst the date of a meeting was X date, there were multiple engagements happening with the ambulance service. And I can remember personally on a Sunday being in our offices in early February where we had a potential case and being on a conference call, because I was helping in the contact centre, because the ambulance service were trying to work out the logistics with the health board. So they were aware of it, of the risks of Covid, at the same time as we were when we briefed the NHS.
Q. And talking about the NHS, the Health and Social Services Group coronavirus planning and response group we dealt with that with Dr Goodall this morning, but that group started on 20 February 2020. You've told us that prior to that you were in contact with the NHS --
A. Yes.
Q. -- the ambulance trust; is that right?
The First Minister, Mark Drakeford, has said in his statement that at times the relationship between the Health and Social Services Group in Welsh Government and Public Health Wales was difficult.

Do you agree with that?
A. Without an example -- it would be helpful if there was an example. I -- and, I mean, having read that paragraph, the beginning of the paragraph is in the context of data, I think, that's right, data and modelling --
Q. He goes on to say, if it assists, that during the pandemic -- he says "We needed it to be more in the delivery space, such as ramping up testing capacity, but it struggled to be so effective". And then he goes on to say that as ministers you only hear about what goes wrong.
A. So if I could perhaps cover the first element, around the -- the beginning of that paragraph --
Q. Yes.
A. -- around data, and then perhaps make a comment around scaling up services, particularly testing.
So there were times early on, I would say, earlier on, where there was such a rapidity of questions and requests for data, understandably, from colleagues in Welsh Government, from ministers -- and I mean multiple times in an hour, through the day -- and we had put all of our data analysts from across the organisation into our Communicable Disease Surveillance Centre, and so to keep up with those was a challenge.

Sometimes, on occasion, there were the same question coming from different parts of the Health and Social Services Group, and later in the pandemic we created a group that could co-ordinate that better, and we tried a number of times with that. And also there were times where through the course of the pandemic we were asked to add additional fields to the population surveillance dashboard that we'd published, which expanded rapidly. Sorry.
And I can remember an engagement with Andrew Goodall, I think it was probably in the summer, where we'd been asked to add a significant number of additional fields, and it just logistically wasn't possible in the time they asked for if we wanted to have the quality of the data integrity. Because in order to do it we had to test the source data. So we had to negotiate on occasion.
So that's what I'm assuming. That's how I interpret the First Minister's comments. I would say that there was some frustrations from our side as well and every few months we tried to create that -- a better control system.
The meeting I referred to was, I think, from September/October. A number of our team met weekly with the Chief Statistician for health so that they could

plan in advance as we were getting into adding vaccinations, as we were getting more knowledge, and again that system helps improve that co-ordination.

In relation to the First Minister's comments about the delivery elements --

Q. Yes.

A. -- of the organisation, so going into Covid we had around 2,000 staff. Two-thirds of those staff were in our public health services directorate that Dr Sandifer led at that time, and that directorate delivers all of the microbiology for Wales, with the exception of two health boards, all of the eight national screening programmes for Wales, and all of the health protection service -- technical service for Wales. So service delivery was a big part of the organisation.

The challenge around testing, and I don't know whether you want me to explore that now --

Q. Well, I was going to ask you if it was Public Health Wales' view that it was for that organisation to be carrying out mass testing?

A. So if I may, so the end-to-end process of getting a result from a test begins with sampling, which is the swab. So without the swab being taken, the swab doesn't arrive, we can't do the test and the test result doesn't come out. So a lot of the time people refer to testing

as a catch-all phrase, but actually it's the taking of the swab and doing the test.

Now, our role predominantly is doing the test, in the lab. That's what we do. Early in the pandemic, we did do the community swabbing for -- as the odd patient case came through, because we were supporting health boards in ramping up their capacity and capability to do that, and that was happening through February. And then I think the Chief Medical Officer wrote on 10 February to health board chief execs clarifying expectations of establishing community testing units, which were the swabbing units.

So our role absolutely wasn't to do the swabbing part of testing, although we did it for the first two months or so to help health boards. Our role was about the diagnostic elements of testing. And I think you have in the statement that we were really fortunate with our team to have created a domestic test at the end of January, which the Chief Medical Officer then approved at 7 February, and that enabled us to have that domestic resilience in complementary to what was happening in the UK Government.

Now, at that time, every country pretty much in the world was competing for the ability to test, and again, if I may, there are three critical things to testing:

one is having the staff; two is having the equipment, the platforms, the machines; and the third is having the chemicals. So if any one of those are significantly dampened, you cannot optimise testing.

So we had -- we had the staff to do reasonably high volume testing of -- certainly up to 5,000, which we got to at the beginning of May. We had made -- we'd had investment from Welsh Government in 2019 to diversify our machines across Wales, which meant that we could use different test kits and we weren't overly reliant on one or two companies. And in March we procured more of those. The biggest challenge was the chemicals.

Q. Thank you.

Duncan Selbie, who was the chief executive of Public Health England, told the Inquiry in Module 1 that his understanding was that Public Health England would create and roll out the test, but then it would be rolled out to the NHS, and it was never an assumption, as far as he was concerned, that mass testing would be carried out by Public Health England.

Is that a similar understanding that Public Health Wales had about its role?

A. We're designed slightly differently. So within our core functions is actually doing microbiology diagnostics. So --

Q. On a mass scale?

A. Well, for the NHS. So if you get admitted through the emergency department with a potential infection, the sample's taken, and it's our laboratories based in hospitals that would do that infectious disease testing, and we have some international leading units within that, apart from Aneurin Bevan health board and Cwm Taf Morgannwg health board, who have retained some services, but we work very closely with them.

So we were, if you like, then, the NHS's testing service for infectious disease, whereas Public Health England have got specialist virology laboratories for, if you like, more the high-consequence infectious diseases.

Q. Thank you.

Can I ask you about the Public Health Wales health board meetings, please, which started in February 2020. Did those meetings support the early implementation of home and community testing facilities across Wales, you say in the absence of other structured response arrangements?

A. So I think you may be referring to the additional meetings that my team put in place with directors of public health in health boards. I think those were -- we -- in addition to that, we were meeting with health

boards -- oh, sorry.
Q. I've got meetings with health boards starting in February, and then meetings with directors of public health from March --
A. Yes, sorry. We had so many meetings, apologies.
I think you may be alluding to, in early February I contacted my colleagues, health board chief executives, suggesting that we did one-to-one organisation-to-organisation calls with them. And, yes, that was very much about -- and I think I shared the agenda -- where they -- where we were at as a country, where they felt they were in preparedness, had they done the training for face masks, how advanced were they in setting up their community swabbing.
So we did those very positively with all of the NHS organisations and I think I shared with you the capturing of the output of those as emails that I sent on to the Chief Medical Officer.
Soon after that, we met regularly anyway, as chief executives, with Welsh Government, so that rhythm went in -- I think that started at end of February, and then, as I mentioned earlier, the more rapid frequent directors of public health meetings were put in place.
Q. Thank you.
I've got one more group I want to ask you about,

it's the public health strategic co-ordinating support group.
Can you tell us what the purpose of that group was and why it was established?
A. Yeah, so that -- this came out of learning from the Ebola virus disease outbreak, and during -- that was 2014/2015, if I recall -- during that we were very heavily involved in working with our partners across Wales in anticipation, because it was a real threat at that time, and the local resilience fora were also engaged in anticipation of any potential case that came in.
What we identified, and again Dr Sandifer may be better to elaborate on this because he led on it, what we found at the time was Public Health Wales attending the four local resilience fora, having very similar conversations with them, at a busy time, and also them not hearing the feedback from their colleagues, a similar public health strategic co-ordination group was set up during that time.
And so very early on under Quentin's leadership was the suggestion "I think we need to have -- to do similarly". So I understand that Quentin and colleagues connected with local resilience fora partners who we'd worked very closely with throughout the years, and it

was proposed to establish the Covid public health strategic co-ordinating support group, and that was agreed to, and that started around about 23/25 March.
Q. 23 March, the date of the first lockdown.
A. Yes.
Q. Do you think that, bearing in mind the important role that local resilience fora and the local government played in the response to the pandemic, that they should have been involved at an earlier stage?
A. Yes, I'm not sure exactly when colleagues in Welsh Government directly through their Civil Contingencies Group engaged with them, so I -- it could be that it's much earlier. I do think, though, we felt that it was on occasion, you know, we were holding the hands of the NHS and running forward at speed, and they were holding back, they were holding the hands as well, that we were in a position where we felt we could see what was highly probable coming down the line, by just observing what was happening internationally, and that it was going to move to a whole-of-society situation.
And so, again, I can't comment on Welsh Government, when Welsh Government connected through the local resilience fora to engage with them. We, however, were connecting regularly. So on 25 February I asked the team if we could establish -- if we could run

an exercise for a potential lockdown, and I spoke to the Chief Constable of South Wales Police the following day, and so we brought all the local resilience fora together for that exercise on 3 March to test that out. So they were engaged with us, but I don't know when it was formal from a Welsh Government route.
Q. Thank you.
You've alluded to it already, but you made a comment just shortly before about there being so many groups. Do you think that the routes through which advice was provided to the Welsh Government could or should have been simplified?
A. I think in the early months it was -- it was -- there were -- as I said earlier, there were multiple contacts. When systems started to be put in place, when TAG was put in place, I think that really was the point at which advice was much more helpfully streamlined, because there was a system in place, there were designated groups that -- subgroups that evolved over time, because the advice was about everything. And so it's -- I think it's that, it's that divergent activity. And then structure gets put in place which creates organisation within a very challenged environment.
So the point -- from my perspective, I think the point that TAG was established made it earlier. I'm not

sure, perhaps if that had been earlier, maybe that would have made it more streamline. Yeah.

Q. Do you think that all the various groups facilitated effective multi-agency working?

A. I wasn't -- I didn't attend a lot of the groups, so I may not be the best to answer. I think -- I think it got clearer as the pandemic went on, because it was frenetic in the first couple of months. And then, as I say, as -- the health protection response plan helped because it created organisation, it created a structure, a national, a region and a local structure, and Welsh Government then wrapped its own meetings around that. And those were local authorities and health boards. And I think that was probably the first time where there was that coming together of conversations and sharing and decisions of local authorities and health boards in a way of tackling Covid.

Q. Can we move on to a new topic, please, the provision of data. The Inquiry understands that one of the ways Public Health Wales supported the Welsh Government during the pandemic was through the provision of data. Can you set out, please, the kinds of data that Public Health Wales provided to the government?

A. Yes, and it changed through the course, as you can imagine, of the pandemic. So to begin with it was very

much about looking at the course of the pandemic on how it was impacting on the population. So the impact that cases -- number of cases, the positivity elements of it, where those cases were happening. And then over the course of the first six to seven weeks we were able then to create more disaggregated data at a local authority level. So the course of the infection.

We also provided data in relation to genomic analysis, so the genome sequencing of Covid. We were very fortunate in Public Health Wales and Wales in having a very strong pathogen genomics unit that we'd had for a couple of years, so we made the decision to scale that up very early on, and that was pivotal and at times we were third or fourth in the world in the number of genome sequence. So that kind of data not only helped us look at outbreaks to identify where potential source or interrelationships between cases connected to that outbreak were, and inform public health action, but they also allowed us to track the variants and the mutations of coronavirus coming through.

Then, thirdly, we did a lot of work around obviously the vaccination data as vaccination started, and at the outset we really struggled with collecting data relating to ethnicity and data relating to protected characteristics because it wasn't -- it wasn't collected

routinely to the level that we would have wanted in the NHS going into Covid.

So when we set up, with partners -- Wales set up the information system for contact tracing in June, that allowed us to add data in there, and similarly when we set up the data system for vaccination, it allowed us to add a lot more data on ethnicity and protected characteristics.

And then finally, just as examples, in the April of 2020 as an organisation we wanted to travel alongside the public on this, so we began a weekly public engagement survey, which was "How are we doing in Wales?" with 600 to 700 people, and we asked our -- the population some continuous questions around health and wellbeing, their self-reported state, and also questions in advance of vaccinations or restrictions. And that information was published, we published it -- published that all the time, but it also enabled Welsh Government to track that in informing.

And then perhaps, if I may, just finally, what we also set up in April following a discussion with the Chief Medical Officer and myself, we have a World Health Organisation collaborating centre, we wanted to track what was happening internationally so the team collected data and formulated it into a weekly then fortnightly

then monthly international horizon scanning and learning report. So we looked at the impact on children and young people, we looked at the impact on disability, we looked at how countries were scaling up the functions of a pandemic, and then finally we did health impact assessments of the impact of Covid on different population groups and the impact of different restrictions on people. So there was some broadly population health data that we fed in as well.

Q. Thank you. Can I just clarify one thing that you said. Is it right that during the pandemic Public Health Wales did not have access to data in relation to age, sex, ethnicity, level of deprivation, or population density region? Is it the case that all of that is now available?

A. We had some of that going into the pandemic. We -- and again Chris, Dr Chris Williams, who you interviewed last week, is closer to the specifics of it. But we did have the data that was collected on the NHS patient administration system, which has got, you know, age, sex, address, et cetera. And what -- the two, I would say, particular challenges, though, is that the specific nature of -- you know, the full demographics that represent the nation, we didn't have that, those pieces of data, and so the team were trying to be creative in

trying to assess the impact on black, Asian and minority ethnic people for example, and so we used a piece of software that could provide some sort of proxy in the absence of data.

The other sector that was really challenged around data was the care home sector, and that was a significant challenge. It got better through the pandemic, but the capturing of the data, that I'm sure care homes capture every day, but there wasn't a system that really could be relied on for us to help inform action or look at the reality of what was happening in any sort of systematised data way.

Q. Thank you. Before we leave this topic, could I ask you to look at one document, please.

A. Of course.

Q. It's INQ000299607, and at page 7, paragraph 1.12, this is from "A review of the Health and Social Services Group Response Structure to COVID-19" document, and it says:

"There was a multitude of dashboards being prepared for different purposes sometimes with similar but slightly different data flows. In terms of PHW, this appeared to be done without any regard to what else was happening in the system leading to duplication of similar outputs between [Public Health Wales] and Welsh

Government ... and creating confusion in the media and to the public."

Do you have any comments on that?

A. Yes, I mean, I think we have always -- before Covid, we have the function of communicable disease surveillance, so as an organisation we will always track communicable disease. What we were being asked to do was expand that in depth and breadth.

Now, what I can't say is that every time we expanded it -- that there was no time where we expanded it where we didn't -- it wasn't as a request of Welsh Government. So a lot of our expansion of the dashboards was because, understandably, colleagues in Welsh Government were asking us to do that. I do think, however, that it could have been connected better and should be connected better going forwards, so that -- on occasion -- and I think Chris may have given this evidence -- we were sharing data with Welsh Government having presented it in one way and then the same questions were being presented -- the answers to the same questions were being presented in a different way. So I think it would have -- you know, going forwards, the complementary skills and agreeing what's the best way to design or present it would be helpful.

The final comment I would say is that it's also the

data was presented for different audiences. So we were presenting -- we were providing data obviously into Welsh Government, but we were also presenting data as much as we could publicly. And I think the knowledge advisory service in Welsh Government was -- and I could be wrong -- was more around data for Welsh Government interrogation and use. So again, going forward, being clear about how we work together, not to duplicate, but to be better on the question, that's one of the reasons why we set up the meeting with the Chief Statistician, which started in October 2020, so that we were really clear together and we could plan what that, if you like, the next steps would be and who was responsible for them.

Q. Thank you. I'm going to move on now to a different topic, which is on capacity and funding.

Dr Sandifer in the Module 1 corporate statement says that at the start of 2020 the health protection services in Public Health Wales were under-powered. Do you agree with that statement?

A. I would agree, yes.

Q. In the corporate statement for this module, you describe scaling up Public Health Wales' response as one of the key challenges that you faced in responding to the pandemic. How was that challenging?

A. So if I pick the three functions up, before I do, I think it's fair to say that in 2018 we flagged to the Chief Medical Officer and Welsh Government the concerns that we had that we needed to build more resilience around our health protection, microbiology, surveillance services, and over the course of about six months we did workshops with the NHS and partners, with -- together -- in tandem with Welsh Government, and then in 2019 we put a business case in to expand health protection, microbiology and surveillance services, in order to build pandemic preparedness and resilience.

And so -- and that was approved, in part. And then of course that was -- I think that was around about, I could be wrong, September 2019, and then of course Covid hit, so -- we were able, though, to avail of additional funding then for new platforms, new pieces of equipment --

Q. Which we're going to cover.

A. Okay.

Q. So the Inquiry heard in Module 1 about the fragility of the -- particularly the microbiology services, and heard that the system for dealing with testing, diagnosis and frontline support was inadequate and not fit for purpose and was struggling to deliver on a day-to-day basis; is that right?

A. I think in the first few months for us it was a real challenge, not because of the -- so much the platforms, because we had diversified them, but the biggest challenge was getting access to the chemicals. That was significant. What I would say is in March we procured additional platforms and then in August we put a business case in for 164 additional staff --
Q. Yes.
A. -- which were approved, and, you'll see in the statement, more equipment, but --
Q. So we'll address those improvements that were made during the pandemic, but just sticking to the situation as at January 2020, the funding had come in from the government, can you tell us what improvements had actually been made at that stage in terms of the infrastructure or workforce?
A. Prior to January 2020?
Q. At the time that the pandemic struck.
A. Okay, sorry. So we had procured additional pieces of equipment to be based in local hospitals, which means that results could be done rapidly locally without having to be transplanted to another part of Wales to be tested.
Q. In how many hospitals?
A. I think we had nine. I will go away and confirm, if

that's okay. I think we had nine what we call "hot labs", which are rapid diagnostics.
Q. So you had nine hot labs already in January?
A. Yes, I will check on the number but I'm pretty sure it was nine. And that allowed for rapid diagnostics.

We also had some additional communicable disease surveillance teams that were starting to be appointed. I think we made -- we'd appointed a couple of additional consultants.

We -- I'm not sure if we'd managed to appoint any additional Health Protection Team, because it was -- by the time it was approved in say September 2019, to mobilise and recruit all of those -- obviously it was -- we went straight into the pandemic. But nevertheless the diagnostic infrastructure was better but it still would not have been enough at all to scale up to the level that we needed it to.
Q. Just to clarify, with regard to high-consequence infectious diseases, is it right that they had to be tested in specific labs?
A. Yes.
Q. I think level 3 labs?
A. Yes.
Q. And is it right that in January 2020 that testing was still being done in England?

A. Yes.
Q. So there was no testing capacity within Wales in --
A. For a --
Q. -- relation to HCIDs?

In your corporate statement, you say, Dr Cooper, that in exercising its role and functions, Public Health Wales was not held back in any way by the funding made available by the Welsh Government. There are no examples of insufficient funding curtailing the ability to fulfil Public Health Wales' role and functions in a timely manner in relation to the pandemic.

Do you stand by that?
A. I do. Sometimes on the business cases it took a little bit longer than we'd have liked for them to be approved, but -- and on one occasion it was less staff that we were -- that we'd asked for, but nevertheless it was a significant increase.

So, yes, I don't have an issue with -- every time we put a business case in, most of the time it was very rapidly approved and -- so we were fortunate, actually, in that respect.
Q. So I do want to explore some examples with you.

It is the case, isn't it, that when Public Health Wales set out a business case for additional funding, it was granted --

A. Yes.
Q. -- by the government?

But in terms of timing, on 24 March 2020 you submitted a request for capital funding for Covid-19 testing platforms to be placed at all microbiology laboratories in Wales, and that was to increase testing capacity --
A. Yes.
Q. -- is that right? And that was granted fairly quickly the next day on 25 March 2020.

Is there a reason why that wasn't applied for prior to 24 March?
A. Well, my understanding is -- and again -- that the 2019, I may need to come back and give you clarity around the specifics of it, but we had purchased additional platforms during 2019, but our team was --
Q. This is in relation to Covid-19 --
A. Yes.
Q. -- testing platforms?
A. Yeah. So the platforms to test Covid-19 are -- they're not unique for Covid-19, so they could test a number of respiratory viruses or other viruses, so you can have a -- one piece of equipment that can test a number. So we had to -- it was about making sure we could expand those that could test for Covid-19.

So -- but we could see what was coming down the line, so similarly we knew we had to scale up our platforms, our staff, our chemicals, and that was -- and in March particularly, trying to increase our testing capacity, competing with the global supply chain, was a challenge. And on occasion, whilst we had the approval to purchase them, we struggled to get some equipment from South Korea, and we were in negotiations with Scotland to try and have a charter flight come down. So even though they were approved they were still a challenge to get into the country.

Q. But it's right, isn't it, that in that very crucial initial period, knowing what you knew about what was coming down the line, you knew that there was a need to scale up, so why wasn't the application for additional funding made earlier?

A. I don't know.

Q. Can we move on to 7 May 2020, when a business case was submitted for the establishment of an additional microbiology testing lab --

A. Yes.

Q. -- that was the Imperial Park IP5 lab and that primarily focused on delivering serological testing of Covid-19. Can you explain what that is, please.

A. Yes, so the swab test that people are familiar with is,

are -- which is something called the antigen, which is that someone has Covid at that time. What -- serological is blood tests, and what that blood tests do is it measures whether someone has had Covid within, you know, the last number of months or so.

And so for -- the Imperial Park lab initially was for antibodies, serological testing. That did change over time to antigen testing as well.

Q. How important was that new lab to the response?

A. That was very -- that was very important to us at the time because it allowed us to do very large throughput testing. That was in advance of the Lighthouse labs coming on board, as I'm sure you're about to ...

Q. Before I do, it's right, isn't it, that that new lab became operational in January 2021, and so the same question: why wasn't additional funding applied for before May 2020 for that important new lab?

A. And if I may, the reason why there was a delay is that the lab was novated to the Department of Health and Social Care --

Q. That was later in August?

A. That's right, yes.

Q. But the application for funding was in May.

A. Yes, I think that is absolutely fair questions. I think from -- as we were travelling through the pandemic, and

particularly in those early months, while we knew it was coming down the line, we were still -- we were still unclear about what the scale was going to be and how long it was going to be for. And putting a business case in really early, when we've only got maybe ten cases, is a challenge to seek approval. When the business cases went in in March, it was much clearer that we were -- obviously the pandemic had been declared, and so it was a much more logical sequence of approvals. For the May, though -- as I say, the business case went in May because we weren't sure whether we'd be able to avail of the Lighthouse lab capacity at that time, which meant that we really needed to scale up to another level in Wales.

But I think it's a fair question and I don't know of the specifics of why for the large lab didn't we apply earlier, but I think, reflecting on your March one, we wouldn't have got a business case through with a handful of cases probably if it had been earlier than that.

Q. You applied for funding for six additional hot labs --

A. Yes.

Q. -- in August 2020, and at the same time recruited 162 whole-time equivalent staff to the microbiology service at Public Health Wales.

It was known, wasn't it, that there was a lack of

microbiology staff at the beginning of the pandemic? Why did it take so long to apply for additional funding for that additional resource?

A. Yeah, well, similarly we were trying -- we had -- we were reasonable with the number of our staff and, as I said, we were able to appoint some in that 2019. The challenge was that the more we were learning about the transmissibility and the impact of cases in Wales, the more the expansive reality of we're in this for a long time, we're going to need to grow to a sustainable resource.

So I think Dr Goodall mentioned earlier that initially they thought it would be maybe a 13-week epidemic, but of course by the time we got into heading up again by the middle of the year, so August or so -- and that was the tipping point, really, when towards the end of August we saw the rates really kicking up again, and that was Alpha kicking in, then it was clear that this is going to be a rolling pandemic. And so for the government to commit to recurrent resource, expensive resource, for 164 new people, that's a big recurrent amount. And together with all of the additional investment. Again, earlier on, I think the wisdom was -- and I think amongst some, was, well, actually this may be more self-limiting than it became. And then

again, as Dr Goodall mentioned this morning, it was clear that they needed to have recurrent infrastructure that was here. So I think that was really the timing that -- that spike in August. And the discussions we were having with Welsh Government in August was: how are we going to do rapid turnaround time when we've got another wave coming, and Test, Trace, Protect is bedding in but it needs to expand to the next level?

So I think that was really more about the situation at the time.

Q. Thank you. So that's microbiology staff?

A. Yes.

Q. I just want to do one more example, please, in relation to health protection --

A. Yes.

Q. -- staff.

There was an application, wasn't there, in November 2020 to increase resource in that department, and in fact there was some negotiations with the government and it was finally approved in February 2021.

You recruited, didn't you, an additional 109 whole-time equivalent health protection staff?

A. Yes.

Q. Do you think that if that application had been made much earlier, and had been granted much earlier, then you may

not have had to suspend some of the other essential services that Public Health Wales was providing, such as screening?

A. Yeah. Sadly, no. The reason being that the decision for us to suspend screening on 18 March was because we'd moved into the delay phase, and moving into the delay phase, if you recall, moved us into people with symptoms having to self-isolate or contacts of cases having to self-isolate. So that's the first point.

The second point -- which meant that we may not have the staff to run our screening services and screening participants may not be able to attend.

The second point was, with the Minister for Health and Social Services' announcement on 13 March, it meant that the re-profiling of NHS services took place pretty much with immediate effect. Now, many of our screening programmes, we commission services from the NHS to deliver elements of those pathways, which ceased at that point. So that was the reason why, unfortunately, we had to suspend screening services.

Q. Do you think that any of the delays that we have just covered had an impact on the response to the pandemic?

A. I think the microbiology -- there was a natural cons -- flow to that, which travelled through the course of the pandemic. I think though with health protection, I --

when we moved into the health protection response plan, that made life easier for us because we now had a much more clearly demarcated role.

However, as we were going into a series of other waves and clearly -- our -- the scaling up of keeping on top of outbreaks and surveillance meant that we had to expand. And also at that time, if you've seen the cover letter, we knew that Covid had such a significant harm on the broader population health that we needed to be moving to a point where we could reactivate our other non-service related activities, because everybody was mobilised in whole or in part, and so, without additional health protection people to replace others in the organisation who had moved into those roles, we weren't able to actually start to kick back in on our broader statutory functions around protecting the public.

Q. Finally on this topic, are you satisfied that the current capacity is such that you are able to scale up resources sufficiently and quickly in the event of another pandemic?

A. I'm really relieved to be able to say I -- we're in a much better position, and we were actually able to get 122 additional staff into our health protection, the others were vaccination leads. So we're -- I mean, 300

additional staff into health protection microbiology over the last couple of years puts us into a much better position.

Q. Thank you.

The next topic is the initial period between January and March 2020, and we're going to be dealing with the details and the chronology of events with Dr Sandifer tomorrow, but there are a few issues that I would like to deal with, with you, please, starting with the Public Health Wales emergency response plan.

It's right, isn't it, that on 22 January 2020 Public Health Wales invoked that plan and the response level was set at an enhanced level?

A. That's correct.

Q. If we can display the handbook, please, it's INQ000056285.

And at pdf page 16, we can see there the Public Health Wales response levels. We've just covered that the level that was set on 22 January was at the enhanced level and it says there that an enhanced response is:

"-- where ... [Document read] ... above those provided by normal operational capacity."

And that type of incident is responded to by a silver group.

Can you help us as to what kinds of incidents may

require co-ordination and resources above those provided by normal operational capacity?
A. Yes, of course. So where we are requiring additional resources into the response to an incident, where we have significant business continuity elements across the organisation such that other parts need to be mobilised in, and where we are being asked such a volume of demand from partners, that actually we need to move into another level of organisation around that.
Q. Sorry to interrupt, but can you give us examples of the types of incidents where that sort of level of response might be appropriate?
A. So, for example, if we -- during the Ebola virus disease. Now, we fortunately didn't have a case in Wales but we had a highly probable case in Wales, and we reacted by obviously setting up our incident management team and were ready and prepared that if that had been a case, we would have gone into an enhanced level of response, which includes setting up a gold command.
When we were responding to NATO -- so in 2014 NATO came to Newport, and in 2017 we had the UEFA Champions League cup final. So in -- during NATO we had our gold equivalent running. We had our silver equivalent running in the preparation and planning for NATO.
Q. And we can see that a major incident, the scale of the

incident response required for that is a more significant mobilisation of resources and a level of strategic response --
A. Yes.
Q. -- is that right?
Can we look at page 19, please. We can see there that when the enhanced response is activated, that would require notifying the executive, appointing a tactical incident manager, and establishing a silver group.
Would that normally be done at the same time as activating the enhanced level response?
A. Yes.
Q. And then for a major incident, you'd appoint a strategic director as well as a tactical incident manager, and you would establish a silver group and a gold group if needed.
A. And if I could say, under "enhanced", that's -- obviously that's also an option of -- under our enhanced level, is appointing a strategic director in gold group.
Q. Just briefly, could you please explain to us the difference between a gold group and a silver group?
A. Of course. So our gold group is the strategic leadership group of the organisation in responding to an incident, so it sets the objectives, it sets the overall arching(sic) response plan, it considers

information coming through and adapts accordingly, and it identifies actions that the organisation needs to take.
The silver group takes that direction from gold and enacts those actions, in essence, so mobilising the organisation, setting up cells or whatever that's needed.
Q. Thank you.
Can we go to the previous page, please.
We can see there the escalation from a bronze group up to a silver group up to a gold group within Public Health Wales. To the right-hand side we can see that a strategic co-ordinating group might feed in. Is that a multi-agency --
A. Yes, we feed into it.
Q. I think the arrows go both ways.
A. I know, it's probably --
Q. But is that normally led by the police?
A. It is traditionally, yes, it's part of the civil contingencies mechanism.
Q. And the tactical co-ordinating group?
A. Similarly. So in the same way, if there was a multi-agency incident, like a factory fire, our strategic director would attend the strategic co-ordination group and our tactical or incident

director would attend the tactical co-ordinating group as part of local resilience forum mechanism.
Q. And what's the Emergency Coordination Centre (Wales)?
A. So that is the Welsh Government's units centre that it's -- that it chooses as part of the civil contingencies approach as to whether -- when and whether or not it establishes it. Its primary function is to assimilate data from partners across the country, to present that for government, for ministers, but also to be a centre of information to support ministers attending COBR. So it's -- if you like, it's an intelligence cell that provides some co-ordination of situational awareness.
Q. So is it the government's way of nationally co-ordinating a multi-agency --
A. Yes.
Q. -- response to a major incident?
A. Yes. And on occasion the ECC(W) may establish a strategic, national strategic co-ordination group itself. So if there was a national power outage, for example, we'd expect a national SCG running out of ECC(W), and so the respective levels would participate in that and would feed information down and feed information back.
Q. Does Public Health Wales have any say in whether that

particular group is set up by the government or not?
A. No, I mean, we -- the decision is that of ministers to establish, if -- I think if I'm correct in saying, and that goes through their civil contingencies process.
I think I'm correct in saying that a Category 1 responder can suggest or propose or feed in suggestions around ECC(W) being set up, but the actual decision to establish it is that for government.
Q. So the enhanced level response internally within Public Health Wales was set up on 22 January, but it's right, isn't it, that the silver group wasn't set up until 28 January? Is there a reason why it wasn't set up on the same day?
A. No, I think it was probably more about ascertaining the information and understanding what was happening. What was unusual for us, though, and it's worth pointing out, is that Quentin and I had the discussion and Quentin became strategic director on the 22nd, and we had our first incident management team --
Q. I think it may have been the 28th -- forgive me for interrupting. I think he was appointed the lead strategic director on 28 January.
A. No, he was -- yeah, sorry, so he was appointed strategic director on 22 January. What happened at the following week is that we added two other members of the executive

team so to give some resilience to strategic directors. And just -- just for formality, Quentin became the lead strategic director, but he was -- he was designated as strategic director on the 22nd.
And then we had the incident management team for the incident on the 23rd, which then helped influence what the resources would be required for silver to mobilise on the 28th. So there wasn't a delay, it was just the running of the order.
Q. So you've told us that a gold group sets the strategic leadership and objectives in relation to a major incident. Why was the gold group not set up until 25 March?
A. So --
Q. Sorry, 25 February.
A. Yeah. So bearing in mind we'd set up our incident management team and the silver group before we had had any cases in Wales, so we were on a daily incident management teams with the rest of the UK, we were obviously seeing -- trying to help support, mobilise the NHS, and more and more information was coming to light, because it was still really -- whilst it was very busy, it was still very, very early in understanding coronavirus and the transmission.
And then on 24 February we had a strategic stocktake

meeting with the Chief Medical Officer on a Monday, following a meeting that I'd had with our incident director on the Sunday just to say: okay, let's just take stock here, where are we at in Wales? What's happening across the world?
We were still yet to have the first case in Wales, which wasn't until, as you know, the 27th, and it was announced on the 28th, and out of that meeting we said: actually, now is the time for us to set up a -- establish a gold group. Which met on the 25th.
That didn't -- that preceding time Quentin, as strategic director, was still directing the response, so I don't think that there was any disadvantage in us not having that until the 25th. I think it was really more about the timing of escalation of the response.
Q. Is it right that on 27 February you attended the Welsh Government health and social care leadership meeting?
A. Yes.
Q. Am I right in understanding that that didn't have anything to do with the Covid-19 response?
A. That's a Welsh Government meeting, and obviously Welsh Government sets the agenda for that meeting.
Q. So it wasn't to do with Covid-19?
A. Well, the agenda was -- the -- Covid-19 wasn't on the agenda to begin with. It subsequently became so because

the Chief Medical Officer and I did a session.
Q. Well, I was going to ask you about your informal meeting during the lunch hour with the director general for Health and Social Services on that day.
You say you shared your concerns with him on that day about the need to scale up services and the importance of preparing and co-ordinating the NHS in Wales for what was to come. First of all, is it right that no minutes were taken of that --
A. No, it was literally over, grabbing food over lunch.
Q. Did he appear to you to understand the seriousness and the urgency of what you were explaining to him?
A. Well, what we shared was pretty sobering. I know that the Chief Medical Officer had been engaging with the director general before that, as had I, with email exchanges. So I'm assuming that the Chief Medical Officer, as Dr Goodall said this morning, would have been keeping him appraised.
We were significantly concerned at that point, and during the meeting we went through where we think -- where we thought the NHS needed to be, and then in the afternoon, you'll see in the agenda, I was talking about something really not important in the context of Covid and so we changed -- the Chief Medical Officer and I changed that early afternoon and he and I presented to

the group, which comprised chairs and chief executives across the NHS, and shared very sobering facts around where globally, Europe, Italy, Wales were at, and in fact that night was the first case in Wales, and it was very much about "act now".

Having said that, NHS organisations had already been -- we'd been working really, really closely with them up to that, but I think people found it difficult to actually tangibly recognise that this was -- this was coming.

Q. You say there that on the 28th the first case confirmed in Wales was announced. On 2 March 2020 you sent a letter to the Minister for Health and Social Services, Mr Gething, and told him that:

"The organisation continues to be at an enhanced level of response in keeping with the other four nations' public health agencies ... [Document read] ... incident and services were being structured accordingly."

Why didn't you escalate the response level to major? Why did you feel like you had to keep in keeping with the other nations?

A. It wasn't just in keeping with the other nations, but also in keeping with the NHS. So the rhythm that was happening was really more about business continuity than

major incident. That letter followed the decision of the board on -- and apologies, I think I said the 24th this morning, but it was 28 February, to mobilise the organisation into this, and so really by that time it made no -- how -- whatever we'd labelled it, we'd mobilised the whole organisation.

So we refused -- we reviewed the level, the incident level, every time we had a gold meeting, and there were times where we had really quite big debates about it, and we reached the point -- in fact, out of it we provided some more decision-making guidance, because we'd stopped all other services. Whether we'd have declared it as a major incident, which has different connotations for the rest of the country if the public health institute has declared a major incident and others aren't at the rhythm of that. Regardless of that, that wasn't the reason why we didn't do it. We were already behaving as if we were in a major incident, because the whole of the organisation had been mobilised in to responding to Covid.

Q. Do you think the Welsh Government would have taken it more seriously if you had escalated it to a major incident?

A. I don't think our declaration of anything would have, to be honest, made any difference because there was just

such a lot of ... I mean, whatever one particular organisation had done or declared, I think in the grand scheme of things it was moving so fast, that really wasn't particularly significant to others.

MS JUNG: Thank you.

My Lady, would that be a convenient time for a break?

LADY HALLETT: Yes, certainly.

MS JUNG: And just to confirm that Dr Cooper is the last witness for today.

LADY HALLETT: Very well.

I'm sorry we're going to have to keep you a bit longer, but I promise you we will finish --

THE WITNESS: That's all right.

LADY HALLETT: -- your evidence today.

I shall return -- perfect timing, Ms Jung -- at 3.15.

(3.00 pm)

(A short break)

(3.15 pm)

MS JUNG: Thank you, my Lady.

Dr Cooper, you say in your statement that from the second half of February that the Welsh Government stepped up and that there was a key change of tone from the government to when, not if, and there was

a commitment to stepping up and oversight across the system in Wales; is that right?

A. Yes.

Q. Do you think that that key change of tone from the government came too late?

A. I think -- bearing in mind by the end of January we were seven days a week as an organisation, many of us. We'd been working really, really closely with the Chief Medical Officer, as I mentioned earlier, in a pincer movement often. And there were some elements that -- as I described, of holding on to the NHS and running with them, that perhaps would have benefitted from a little bit more performance management, perhaps, just to help people get a bit faster on some of the areas, notwithstanding the fact that they were helping.

So I think -- I think it would have benefitted if there had been more proactive engagement earlier --

LADY HALLETT: By ministers?

A. I'm not -- it's -- not necessarily ministers, because I'm not sure they would have -- there would have been much that they could have done that would be that much different, but I guess it's the collective of Welsh Government that ... I know the Chief Medical Officer had a small team, and there was a lot of transactions happening, a lot of discussion, lots of meetings, and so

to have fortified his team to be able to deal with that, but also perhaps to set the battle rhythm. And I put it as one of my lessons learned in my personal statement that: set the battle rhythm early, you can always stand it down.

So I think it would have benefitted from that. I'm not saying necessarily it was health, I think perhaps more of a civil contingencies engagement earlier, back to the "Get the battle rhythm going, you can always stand it down".

So I think it would have been beneficial if there had been broader engagement, notwithstanding that the Chief Medical Officer was right in the eye of the storm with us.

MS JUNG: So is it fair to say that the Welsh Government's delay in mobilising and taking control of a national co-ordinated response deprived Wales of precious time to get ready, equip itself and fortify itself for the pandemic?

A. I'm not sure of the cause and effect. I think there was a lot happening, the first pressure point was always going to be the NHS and social care, and so we were helping ramp up the capacity, the swabbing capacity, et cetera, with the NHS. So I'm not sure of what -- whether -- what tangible impact it would have had.

However, I think setting the expectation for planning earlier would have helped, because -- and I think I shared with the Inquiry a number of emails that literally within a week the world had changed again. So I think it was more around the planning.

I'm not sure I would say that it was quite the cause and effect that Wales was at a detriment to that, I think it was really about expediting activities and perhaps getting the local authorities involved earlier.

Q. Could I ask for your personal statement to be displayed, please, that's INQ000276282, at paragraph 98, page 22, please.

At paragraph 98 you say:

"With the exception of the Chief Medical Officer and his team (with whom we were working closely from the point of becoming aware of Covid-19 in early January 2020), in my view the wider Welsh Government did not appear to fully appreciate the seriousness of the threat of Covid-19 until the middle of February 2020, after which, Welsh Government quickly mobilised from that point."

Do you stand by that?

A. Yes, and I think in the preceding or following paragraph there was -- there was a lot happening at that time, there was the EU transition happening, there was,

you know, some environmental challenges, the flooding in Wales, so certainly the civil contingencies team I'm sure would have been very busy anyway. But, yes. I can't comment on what was happening within Welsh Government, so I could be doing them a great injustice, but I think for us the main contact really was the Chief Medical Officer and the team. That doesn't mean to say that other activity was happening in Welsh Government on this and I wasn't aware of it.

Q. In your view, did Public Health Wales do enough to make the government understand how serious and urgent the situation was?

A. I think you can always do more. We did a lot. You know, we were literally, with colleagues, mobilising the NHS, we were putting in place plans to try and -- we were trying to be two steps ahead as much as we could in those early days, and, you know, obviously the Chief Medical Officer has his own internal engagements going on within Welsh Government, but, look, you can always say you can do more.

I'm not sure what more we could have done. You know, perhaps a formal letter from me. But I'm not sure it would have made that much difference. And I think for me what was quite an important point was when Dr Goodall came and then the minister came to our

offices on 11 and 13 March, and they -- when you see half a very large office covered with people with high-viz jackets on, a whole National Contact Centre, whiteboards with, you know, tens and tens of people's contact initials on, or numbers on, suddenly it becomes tangible. And to be honest, I think what was -- the challenge was that people couldn't -- they were distanced from it to an extent, perhaps to not -- it wasn't palpable to them. Yeah.

Q. Thank you.

Can I move on to another topic, it's the Seren City exercise that you've already referred to, the debrief report is at INQ -- oh, thank you, it's already up.

Can we look at page 2, please. We can see there that this exercise was a strategic multi-agency tabletop exercise held on 3 March 2010(sic), and it was commissioned by you, the chief executive of Public Health Wales, and the Chief Constable of the South Wales Police.

LADY HALLETT: 2020.

MS JUNG: 2020, thank you, my Lady.

Why did you commission this exercise?

A. So, as I mentioned earlier, we were -- we were watching the world and we -- very quickly in January we had a growing sense of seeing the tracking, what was

happening globally, Europe, and as I mentioned earlier what was coming, but until it was here it was difficult to get other people in the mindset that it was coming; back to it not being tangible.

So on 25 February I just thought we need to test a lockdown. That wasn't due to any other intelligence, I didn't have any intelligence, no one -- it's just it felt logical for us. We're an organisation that does quite a lot of exercises, so if there's something happened like Novichok, within a couple of weeks we had an exercise across Wales around Novichok.

So it seemed logical that, if this panned out into the worst-case scenario, we needed to test something. None of us knew what was going to happen, so ... and when I spoke to Matt Jukes, the Chief Constable, the following day and said, "Look, what d'you think?" and he said "Yeah, let's just do it". So we had a -- people were face-to-face, so it was a face-to-face meeting, so it was really based on try and -- hoping it would never happen but just to test something that we hadn't tested in Wales before.

Q. Did the exercise conclude that a local lockdown was an effective countermeasure?

A. The exercise wasn't really set up to say yea or nay, it was really to test: should we be in that situation,

where would the gaps be? And so if you looked at some of the observations and the recommendations, one was, for example, about legislation: did we have the powers, should we be in that situation? What about the public engagement, how would that pan out? So it wasn't a kind of: is it a good thing or not? It was really just to say: what do we need to start thinking about, should this situation arise?

Q. One of the recommendations was for the Welsh Government to produce a paper on the key lessons identified in the exercise. Do you know if that was produced?

A. I don't know.

Q. Also specified in the debrief was that guidance on PPE was led by PHE, with input from Public Health Wales. What did Public Health Wales' input amount to?

A. It was an ongoing input, so we -- one of our incident directors was very closely involved all the way through the pandemic, in fact chaired the national infection prevention and control group, and was involved in the nosocomial national group as well. So we provided public health advice to help -- not only to contribute to the UK guidance. So for things like infection prevention and control, it was very much a UK-led on around guidance.

As far as the specifics of PPE is concerned, our

involvement was always -- we weren't directly involved in procuring PPE, it was providing advice, which one of the incident directors did through the pandemic, and of course the timing of this, 3 March, very soon after this we were on an exponential experience, so the -- the extent to which people took on the actions, I think some of the actions became real.

Q. Bearing in mind the thinking on lockdown as an NPI had started as early as 3 March, do you think that the first lockdown happened early enough?

A. Well, this was our "Let's test something", it wasn't intended to be policy, but you -- I was here with the -- your evidence session with Dr Goodall earlier and when he was talking about contact tracing. So I would say there's two salient points in March, the point of going from containment to delay on 13 March, and then the lockdown.

So that 12/13 March, ourselves and colleagues across the UK, we didn't have the capacity to cope with all of the contact tracing. It was exponential as more and more countries were put on it. And also we got to the point where we knew there was now community transmission, which meant something needed to change because the model was not sustainable.

Certainly the signals at that time were that this --

we are on, you know, a rapid increase curve here, and if you asked me: do I think the lockdown should have been earlier? I think, yes, it probably should have been. I'm not a technical expert so, you know, colleagues would be able to give far more evidence based on that, but it felt as if -- at that point of 12 or 13 March, we ended up escalating a series of meetings with the NHS that night, and we happened to be with the minister the following day because he came to our offices, and then of course the NHS re-profiling happened that evening.

So I think if there was a more natural point, it was probably closer to that --

Q. Thank you.

A. -- than the 23rd.

Q. Three days after that exercise was the Newport v Benetton Treviso rugby match.

A. Yes.

Q. Dr Williams advised in relation to that that he didn't think the match needed to be cancelled.

It's right, isn't it, that in relation to the Wales v Scotland rugby fixture on 13 March, Public Health Wales' advice was different?

A. Yeah, I mean, I think it's difficult because in around that time SAGE, if I can recall -- and obviously we weren't part of -- directly as part of SAGE, but there

was an evidence that was a bit equivocal about mass events and the contribution to mass events, and so Chris -- that was a week, two days after this -- Chris's advice was based on that SAGE advice.

A lot happened between 5 March and by the time we got to 13 March, and our advice was in a conversation with the minister. As we'd outlined in the statement, it was the day before the match was due to take place. I was with one of my other incident directors, Dr Howe, and the discussion came up, and it was really that on the basis that, even though the event itself -- there may not be evidence to support the event itself, the concern really was about transport to, socialising after, and so our -- it wasn't a formal advice, but our recommendation was for them to consider cancelling. At that point, as you know, the decision was still for it to go ahead, and then WRU cancelled it.

Q. In your view, should mass gatherings have been banned earlier in Wales?

A. I mean, you know, I'm going to play the technical expert card here because I relied on all of my team through this, so I'm not the person to ask.

My personal view, which is a non-technical view, is it's difficult, isn't it, when -- we hadn't moved into the lockdown. So actually at that point, unless you've

had a case or you were symptomatic, the public weren't -- or if you were in a high-risk environment, whether it's hospital or care home environment, where you were really feeling it, the general public were or weren't experiencing -- when we went into the lockdown, it took it to another level.

So I think at that time I ... I think it would be -- if the evidence was equivocal, it was quite difficult to make an arbitrary decision. My personal view, though, is about the behaviours, social behaviours. I think that's the challenge. Because if you say you can do X and you can't do Y, and Y is something that's quite large -- but you still have to follow some of the evidence. And I think the story particularly of Covid in the first year was -- balance of evidence, it's not -- not everything was clear-cut.

Q. You said that everything was moving along very quickly and changing. In the next couple of days there was the Wales v Scotland Six Nations rugby match, and also two Stereophonics concerts. It's right, isn't it, that Public Health Wales was not asked to advise in relation to those events?

A. No.

Q. Do you think it should have been?

A. We weren't going out seeking to be asked to advise on

them, because, to be honest, we were just so busy ourselves. Well, we were asked around the Newport v Treviso, as you've outlined, and we gave -- we proffered advice around the Scotland/Wales because it was fortuitous with the minister in the office. But I ... yeah, I mean, perhaps it would have been helpful. I'm not sure whether it would have changed the decision, to be honest.

Of course big matches are commercial decisions that aren't a government decision to be made, and in advance of the lockdown -- that changed everything, really. So I think it was -- I think it would have been a difficult dynamic for them because there was an order to things, and it wasn't -- perhaps it wasn't quite the time for them to edict a decision by the WRU, for example.

Q. Can I ask you about the Public Health Protection Response Plan that you were asked to develop by the government, by the Chief Medical Officer, on 22 April 2020.

The plan recognised, didn't it, that Wales had had to respond rapidly to the pandemic, and that it had had an unprecedented impact on society as a whole, including that many people had died? It said now was the time to prepare for the next phase of the pandemic, was it an opportunity to pause and reflect and learn from past

experiences.

So bearing that in mind, to what extent did that response plan take into consideration indirect harms from Covid-19, including for example on mental well-being?

A. Yeah, so really a key point. So when we moved into the delay phase, and -- sorry, moved into lockdown, it did calm things down for us, and it gave us an opportunity to really take stock. We were already starting to think about the next phase before the Chief Medical Officer asked us -- in fact that triggered the question -- and we'd already been doing work since April on the broader harm.

So I mentioned the international horizon scanning report. We also had already started a health impact assessment on mental well-being for -- on social -- sorry, on staying at home, social distancing, which was really starting to look at the impact of the first lockdown, which we'd produced in June; we were doing a health impact assessment on home working and agile working, and we had a series of impact assessments happening, so we already knew that the impact was really going to be exponentially significant.

So when we did the health protection response plan, it -- we intended to cover the totality of the

population's health, not solely the response to the pandemic, the infection element of the pandemic, but of course everything's connected to everything.

So, you know, seen in health protection response plan that we identified elements about the broader harms and then for us as an organisation we then went into rapid plans for us, so stage 1 which was a matter of I think two, three weeks and then a stage 2 and then we changed our operation plan.

They very much focused on the broader harms. And then in August we set up what I called gold 2, which was our population health broader harms group, and we invested £1 million, moved £1 million of internal money to buy in additional capacity to help us fast-track that knowledge around the broader harms for society.

Q. The plan said that the response to Covid-19 must take into account these wider health and other impacts, but these are not addressed in this plan. Public Health Wales would conduct studies on some of the indirect effects of Covid-19, and it goes on to talk about the survey. A lot of the reports and studies that you talk about and that are exhibited to your statement postdate the publication of the report in May 2020. Are you able to say to what extent those wider health impacts were taken into consideration before the report was

published?

A. By us or --

Q. Yes, by Public Health --

A. Yeah, so as I've mentioned, you've seen our structure, you haven't shown it, but we have got amazing skills around the table, including world leading experts around the broader harms, health equity, and that's why we're a WHO collaborating centre on health equity. So we started that process from April, and that was key for us to not only help rapidly inform Welsh Government's thinking -- and we did a number of themes, we did a health equities theme around the engagement survey, but also we wanted partners to be directly involved in it.

So two things -- and I know we're short of time -- after the Public Health Protection Response Plan was produced, we developed an operating framework for NHS and local authorities for its implementation, and then we were subsequently asked by the Welsh Government to give guidance for local prevention and control plans which included a section around taking into account the broader harms, vulnerable people. Our broader harms stuff just continued, we did a lot of work around the broader harms.

We also, really importantly -- which we haven't

touched on yet -- was the concern around violence against women and domestic sexual violence. So we have two parts of the organisation around adverse childhood experiences and a violence prevention unit that we run with South Wales Police. So already around about May, April/May, we started to do evaluations and surveys around the impact of how children and young people were experiencing violence and adverse childhood experiences, we were doing harm footprint work.

So early on we were looking at what was happening in the broader society.

Q. In Module 1, Dr Sandifer was taken to the response plan and he accepted that there were only three broad categories of vulnerable people considered in it: those with mobility problems, those with mental health or learning difficulties, and dependents such as children; and he accepted in hindsight that that was not an extensive enough description of who should be considered and categorised as vulnerable.

Do you agree with that?

A. I do agree with that. In addition I would say that in the detailed text tables about, for example, in the population surveillance there's quite a detailed breakdown of what's surveillance. There's a lot more categories of people, different vulnerable populations

included in that as far as our anticipation and intention to broaden our surveillance. But yeah, I absolutely agree with that.

That didn't mean that we weren't looking at those different groups, because they -- as we've talked about earlier, very early on it was clear around the disproportionate impact that was happening. But, yes, the main text I would agree.

Q. Mr Goodall says, in his fourth statement for this module, that decisions at the start of the Covid-19 pandemic were often made without a formal assessment of the impact on vulnerable people. And in the corporate statement produced by Public Health Wales, it stated that from October 2020 the formal public health advice submissions generally highlighted the need for certain specific at-risk and vulnerable groups to be separately considered targeted or prioritised.

A. Yes.

Q. So is it fair to say that prior to October 2020 there wasn't a sufficient consideration of those people?

A. I don't think so, but it probably was manifesting in different ways. So, as I have gone through, we set in train quite a significant -- multiple pieces of work to inform decisions around the -- so we did -- one of the international horizon scanning reports was about the

impact on people with disabilities. By the time we got to a vaccination, which is a little bit further, we could look at the impact on people with learning disabilities.

So it didn't mean that we weren't looking at it, I think it was -- it was a challenge in what data was available as well for us to monitor it, and October -- of course before, prior to October, as we discussed earlier, it was a more dispersed process for us in producing advice. So in that October, particularly the 24 October advice note, that allowed us to really central on, you know, short succinct "These are the important things that need to be focused on", and from that point onwards, really from 12 October, they became very prominent.

Q. Thank you.

Can I ask you about the advice and guidance provided in relation to care homes --

A. Yes.

Q. -- and the discharge of patients from hospital.

Can we have a look, please, at INQ000336344. If we look at page 2 of that document, we can see that there is an email, initially, to you stating that there has been contact from a number of care home operators and managers expressing concerns that new residents are not

required to be tested for Covid-19 prior to admission, and it says:

"As you are aware, residents in care homes are amongst the most vulnerable ... [Document read] ... could constitute a significant risk.

"... I would be most grateful if you could advise as to whether ... [Document read] ... why this will not be the case."

If we then look at the response from you above that, you say:

"We recognise the challenge for residential care home operators ... [Document read] ... personal protective equipment by staff."

You go on to say that:

"New residents, should similarly be assessed for signs or ... [Document read] ... test new residents prior to admission."

Now, we know that later Public Health Wales issued guidance which was consistent with that, and then later still the government changed the policy, so that everyone coming out of the hospital was being tested --

A. Yes.

Q. -- in light of the evidence of asymptomatic transmission.

Do you now accept that your original advice was

wrong?

A. Yeah, it's -- taking it into, I guess, the context at the time, this was before Welsh Government had made decisions around testing in relation to care homes, so there was no policy decision on testing at that point. The reference around testing was that at that point the case definition didn't include residents in care homes, if you recall, other than people who were symptomatic, and so what was -- if someone had a fever or a continuous cough, that was the indication for tests. So the testing world was in a different space, and the other element that was a challenge was that if someone had a negative test, it didn't mean that they weren't incubating Covid.

So at this point in time, it was -- the move -- the world changed significantly as we went through April and into May, and we were -- we had about a thousand tests a day, so it was a really challenging time around testing.

Q. I'm going to ask for one more document to be displayed, please.

It's INQ000191663.

If we look at the -- we can see that this is a PHE care home discussion paper dated 18 April 2020, and the third paragraph, can we see there that it says:

"PHE arranged swabbing of all residents and staff in 6 care homes.

"Results from three ... [Document read] ... negatives also symptomatic."

Then below that it says:

"So symptoms poorly predictive of infection (therefore a poor trigger for control measures)."

Did Public Health Wales do any kind of investigation like this by going into care homes and seeing for itself what the rate of positive cases were in symptomatic and asymptomatic cases?

A. We did further, I think about three or four weeks after this, we did, we looked at a series of care homes that hadn't had outbreaks and we looked at -- when we had more testing capacity or all system testing -- all care home testing.

What I would say in relation to this, though, is on 18 April we were -- had been routinely testing symptomatic residents in care homes, since we had the tests available, and on 6 April we started testing symptomatic care home workers as part of the critical workers policy, so -- because another element of this is about the concern around the spread by staff. So everybody was learning as this was materialising, and this was at the time as well when we were working with

Welsh Government to amend the testing policy based on Public Health England's document on 15 April, which was the adult social care plan in which all residents on discharge would be tested.

So on the 22nd, the policy changed here and I think a letter came out from the Chief Medical Officer and the deputy director general responsible for social care outlining that everyone being discharged would be tested and that there will also be a more prompt response into clusters or incidents in care homes.

So this was quite a critical time that also helped change the Welsh Government testing policy.

Q. Given that this was such an important group by size, vulnerability and the severity of adverse impact, do you think that that kind of investigation ought to have been done before you were advising that asymptomatic people did not need to be tested?

A. Well, our -- the advice around asymptomatic -- the testing of asymptomatic people was advice that was being worked through not only by us but also, as with this, the UK-wide incident management team, and the world was evolving around evidence of -- there's a difference between asymptomatic transmission and someone who has it who is asymptomatic, as you know. So we were learning together on this, and the PHE 6 study, which is what it

became known as, it -- just because that was England, didn't mean that we were all learning from that.

So later on in the pandemic, we all did quite a lot of different studies within the countries, but this was just as important to us regardless of which country it had been done, we didn't necessarily need to fast-track one in Wales to not take this on board, and our challenge was testing capacity.

By the time we got -- at this point we had -- we'd increased to a couple of thousand, and then in May we were really able to expedite all of testing. So I think on 2 May we did all testing of symptomatic and asymptomatic staff and residents in care homes with a new outbreak. And then two weeks later the same in care homes without an outbreak, because we were concerned -- which is back to your question -- we were concerned about what was happening in places that hadn't logged an outbreak that potentially could have transmission that wasn't being picked up.

Q. Thank you.

In relation to public health communications, you say in your personal statement that in your view an area that could have been better was in relation to clearer public messaging when there was a clear divergence in restrictions compared to other UK nations.

Can you explain what you meant by --

A. Yes, I think it was a challenge because regardless of the policy strapline or, you know, the public communication, you've also got the media. So in the first few months the UK media tended to default to the decisions that were being made by the UK Government vis-à-vis England. That did improve, and as the months went by they would differentiate, that in -- this is what's happening in Wales, this is what happens in Scotland, Northern Ireland, England, but in the first few months it became really confusing for people.

I think when we -- when Wales, when all of the countries started to diverge, particularly coming out of that first lockdown, I think there were a number of occasions where a strapline of a policy created quite a lot of problems in other countries that were still being a bit more cautious. I don't think there's any easy answer to solve that.

I think the early engagement with the media is really key because people will tend to default perhaps to the UK rather than the national -- so whether there is an opportunity to work more closely with the media at the outset, possibly.

The other elements really was about ensuring -- which we worked closely with the Welsh Government on --

after a few months, was the behavioural insights messaging. So if you're going to change your message, you have to perhaps tailor it more to the view of the mood music of the population, and then also further tailor it to different population groups.

So I think there is learning in there for us.

Q. Thank you.

And finally, on reflection, is there any other learning that you would like to highlight? Is there anything that you think Public Health Wales could have done better?

A. Oh, I'm sure there's lots and lots of things that we could have done better. I think the key -- three key learning points really. I mentioned -- one I mentioned earlier was just get the battle rhythm up and running.

The second I would say is about respective roles and responsibilities, because I think they were muddy for the first few months, and having us all lived through this, I think that has improved. There was a health protection review undertaken that the Chief Medical Officer commissioned that was helpful to that. So I think that's the second one.

And I think the third one is, you know, very much about the welfare of staff. So for us we spend a lot of time around the welfare and well-being of our staff, and

trying to do as much as we can on that. Because, you know, people expect an incident to have a beginning, a middle and an end; this just kept going. And so the sustainability, be it a care home, be it a hospital, be it an organisation like us, yeah, I'm not sure enough has been done to say: okay, well, how do we really, really try and address that? We've got more staff now, which is great, but that's not the same as everywhere.

So I think that's a -- that's a continued challenge that I think something needs to be factored into what we can do for learning.

MS JUNG: Thank you.

My Lady, those are all my questions. I believe there are some --

LADY HALLETT: Thank you very much.

MS JUNG: -- questions from core participants.

LADY HALLETT: There are.

Ms Shepherd.

Questions from MS SHEPHERD

MS SHEPHERD: Good afternoon, Dr Cooper. I appear on behalf of Covid-19 Bereaved Families for Justice Cymru, and my question focuses on ventilating indoor spaces and in particular public communications regarding ventilation.

I don't propose to bring it up on the screen, but in your corporate witness statement you set out some of the

public messaging campaigns that Public Health Wales has a role in delivering. These include the wash-your-hands message, the stay-at-home message, and an advertising campaign to encourage pregnant women to get the vaccine.

What's not on the list is a campaign regarding the importance of ventilation.

Firstly, was Public Health Wales involved in a public messaging campaign about the importance of ventilation as a mitigation against the spread of Covid-19?

A. I don't -- I can't recall if we were. Dr Sandifer's giving evidence tomorrow, so it would be worth asking him. So we may have done, I'm not familiar with it, and we didn't put it in the statement, so that may have been no.

Q. I just want to provide some context. There's a document, INQ000220539. Just for context, this is a paper from the Welsh Government, and it just sets out all of the advices that SAGE provided in July of 2020.

At row 39 of that document -- I'll just wait for it to come up. So I don't know whether it's possible to get row 39 up, I appreciate it's an Excel spreadsheet so it's a bit different. We can see in column -- I'll wait for that to come up.

A. Yeah.

Q. There we are. We can see in column E, and it's in bold actually, it sets out that SAGE endorsed the EMG paper on airborne transmission. So EMG, the Environmental Modelling Group, a subgroup of SAGE. In column F, we can see that it's a document that was entitled "Role of aerosol transmission in Covid-19", and this was endorsed by SAGE on 23 July.

At this point, Public Health Wales had access to SAGE advice papers; is that right?

A. Yes.

Q. What's said is that:

"SAGE noted its findings ... [Document read] ... good ventilation."

So if Public Health Wales didn't get involved in a public messaging campaign about ventilation, are you able to say why not?

A. Well, we were -- we were involved closely in all of the advice around ventilation, but particularly in places like schools, and in fact we spent a lot of time providing support. The campaign -- it's maybe worth just saying that the campaigns originated in two ways.

So a lot of the strapline campaigns, as I would call them, were Welsh Government. We didn't design them. We further -- we disseminated them but they weren't -- they weren't our campaigns. We did lead on the campaign to

encourage pregnant ladies to get vaccinated, but I think it's a fair -- it's a fair question.

So I guess my answer is: just because we weren't in -- didn't do a campaign, doesn't mean we weren't involved in it. But I think it's a fair challenge back to say: well, did we think to do one? I wasn't involved in all of our technical conversations, so Quentin may be able to enlighten further. But I think it's a fair question, actually, and maybe that's something that we need to reflect on.

Q. If I could ask one follow-up question: is the reason why it's a fair question perhaps because, as understanding about airborne transmission evolved, the focus perhaps needed to move away from washing hands towards ventilation? Is that reasonable?

A. I think it would be both. I think the hand hygiene was always and will always be a prominent aspect of infection prevention and control. Yeah, I think from the ventilation element there was a lot of guidance on it, and of course it was different in different environments. So whilst you can put, you know, clear principles, the actual public health advice would be different depending on the environments. But I think that's -- it's a fair question, and so I would say it's both and -- and I'll take it back to the ranch as well

and have the conversation about, you know, is that something that we should think about doing, should we be in this situation again.

MS SHEPHERD: Thank you very much, Dr Cooper.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Shepherd.

Ms Foubister.

Questions from MS FOUBISTER

MS FOUBISTER: Thank you, my Lady.

Good afternoon, Dr Cooper, I represent John's Campaign and Care Rights UK.

You've explained this afternoon and in your statement about the role of Public Health Wales, including to provide advice on the indirect harms of the pandemic on population health and well-being, and that your advice recognised decisions needing to balance considerations which included the wider harms of interventions.

If I could bring up INQ000251938, this is the witness statement of Dr Chris Williams, who I think you're familiar with, and when we get there I'm going to turn to page 6, paragraph 25.

What Dr Chris Williams states, about halfway down this paragraph, is he refers to the availability of other viewpoints on the wider questions being very

helpful in moving beyond a strictly infection focused assessment of harms and benefits.

Do you agree with that, and do you accept that the focus ought also to have included the wider harms caused by restrictions themselves?

A. If I can clarify your question, do you mean in relation to what we were doing or in relation to what Wales was doing?

Q. So do you agree that there was, at least initially, a strictly infection based focus, and do you agree that that ought to have considered the broader harms?

A. I think -- so if I answer for us, that's probably easiest.

Q. Yes.

A. So I would say January, February, probably the first part of March, it was absolutely about preventing -- protecting the public and preventing infection. I mentioned earlier Professor Mark Bellis is one of our former directors, so Mark very early on in the pandemic -- he heads a department of WHO collaboration centre -- was saying, "You've got to start to think about the broader harms", which is why in April we started doing that work. And so whilst it wasn't necessarily appearing in our advice, there was a lot of work that we'd put in train because Mark was

particularly focused on it, and I think what Chris is also alluding to is that when we'd got into the more formative advice note stages. Mark would be part of those discussions and we would have quite colourful conversations because it was that balance of our health protection saying, you know, "We need to be really restrictive to prevent spread", and there's Mark saying, "Well, there's the mental well-being and the different aspects of the impacts on the population group".

So that was -- I think that's probably what Chris is saying. But no, in the -- I would say in the -- in January, February, March our focus was about trying to prevent the spread of the infection, and then from April we really started to increase our work on the broader harms.

Q. I'm going to now look at INQ000056334, and this is a Public Health Wales document from 10 March 2021, so the following year, and at page 4, the second paragraph from the bottom -- so this was -- the document itself was a briefing note to the Minister for Health and Social Services, and the second paragraph from the bottom refers to:

"Further restrictions ... [Document read] ... benefits and harms of such actions."

So why was the understanding of the harms caused by

Covid-19 measures still, as of this time, so March 2021, not sufficient?

A. Again, whether it's a question for us or a question for Wales, I think where by March 2021 I think there was, to be fair to Welsh Government, a -- much more of a recognition around the harms in the way that they were making the decisions, then it was the balance of -- around restrictions and the order of letting things or releasing things.

I think for us I'm not sure that'll ever go away as a statement. I think we know before we got into Covid we were facing challenges and the demographics of society, and then obviously since Covid we've had the cost of living crisis, we've got the conflict in Ukraine and climate change. So they all superimpose on the broader harms, so I don't think we can ever do enough on that.

But as far as the restrictions are concerned, it was -- we obviously moved into a slightly different world from March 2021, and what we were trying to position Welsh Government to is to have a much more structured way of tracking the numbers as well, because we can talk about it but if you can't measure it, it's quite challenging. Later in that year we developed a much broader population health dashboard that included

all of the proxies into different parts of society --
Q. Just focusing specifically on this timeframe and what this Public Health Wales document is saying, what steps were necessary in order to obtain the kind of more sophisticated understanding identified in this document? What kind of concrete things do you think this document is alluding to?
A. Yeah, I think it's measurement, and we kind of go on to say it in the document. So at the time there wasn't one, that we were aware of, centrally held point that was tracking the broader harms, be they about well-being, be they about impact on health services, be they about morbidity. So Welsh Government no doubt -- and I'm not close to it -- had the socioeconomic tracking, but we weren't aware of anything that was actually measuring the specific harms around health and well-being.

Now, some of these take years to measure, to be fair, so it's not an easy thing to do. But our point really was more about, as we said in October 2020 -- we said this again, and this followed the meeting with the minister the previous fortnight -- that you'd got to start balancing them, and if the October 24th note that we sent was about getting into a different relationship with the public, in recognition of this, and factoring

that into the pacing and the order of restrictions.

So this covered quite a few areas, I would say.
Q. Thank you.

Just moving to a slightly different topic around communication, you've explained today and in your statement about Public Health Wales' role about ensuring communication, ensuring the consistency (unclear).

If we could bring up document INQ000181725. While it comes up, I'll tell you what the document is.

It's -- the Older People's Commissioner, Helena Herklots, produced a report called *"Care Home Voices: A snapshot of life in care homes in Wales during Covid-19",* and this is a document from June 2020, so fairly early on. And when we get there, I'll just refer to page 12 of this document and the first paragraph in particular of page 12.

What this paragraph says is that there were:

"A number of responses from care home managers and staff [highlighting] the difficulties ... in accessing crucial information and guidance ..."

And particularly the second sentence of this paragraph:

"Particular issues were highlighted about the amount of rapidly changing information that care homes were receiving, often from multiple bodies which was often

confusing or contradictory."

Do you accept that there was sometimes confusing guidance that was contradictory and unclear?
A. I think it was very confusing for care homes insofar as the guidance was changing very, very quickly and sometimes -- there was an occasion where a change to policy was announced and none of us knew it was going to be announced. So our call centres were going wild, and we didn't know it had been -- the decision had been made. So it was a -- it was a very busy time, particularly for care homes, I would say, around that February, March, April into May. So I would accept that.
Q. And specifically on visiting in care homes, do you accept that there were some deficiencies in visiting guidance and, if so, what kind of thing would be needed to ensure that guidance is clear, consistent and comprehensive in relation to visiting?
A. I'm not -- I can't recall exactly the specifics around visiting, I'm not as close to it. But we did put guidance -- I think guidance was circulated in March, middle of March, around really that trying to reduce the ingress of infection, sorry, from different sources but including visiting, and it probably wasn't until the middle of March, end of March where that changed.

I think there were areas with care homes that I think we could have been clearer, Welsh Government could have been clearer, and I think we should have earlier on, whilst we set up an enclosed setting cell which was -- was the only port of support for the care home sector, I think we should have set up settings based meetings earlier so that we could really understand what the -- what was materialising on the ground within care homes. That would have been more helpful to have more or less guidance in; it may not have changed the public health advice. So, yeah, I would recognise that.
Q. Just on that, was there a member of the team who was responsible for producing guidance who fully understood the needs of people in care? And if there wasn't, do you think that that would be something that would be helpful going forward?
A. We had members -- we had a lot of members of the team in our enclosed setting cell, because we accelerated it very quickly, we had people who had quite a strong influence -- influence; experience around the care home setting. We did engage with particularly Care Inspectorate Wales, but I would absolutely agree with what you've said.

I guess what I'm alluding to is not just in care

homes but, having reflected a lot on this, we were working with partners but were -- but I think if we were to run this again, I think we should have that settings based, real lived experience people involved early on in the development of guidance. As I say, it may not have changed, it may not change the public health evidence, but I thought this was a really powerful document, by the way, and having read a lot from colleagues in care homes the reality of: well, if you say to do X, do you realise how challenging that is?

And then I guess my final point on this is all the experience that care homes now have around infection prevention and control, it's how do we help retain and support that for people?

Q. Last week we heard from Stephanie Howarth, the Chief Statistician, and she confirmed that the Knowledge and Analytical Services only became involved in data collection analysis after the early stage of the pandemic and that if they had been asked to advise earlier on, they could have avoided various errors and misreporting. Why didn't Public Health Wales ask KAS to assist at the outset of the pandemic?

A. We were just exponentially increasing our requests to meet the demands from a data perspective from Welsh Government. I guess -- I guess the question is they

could have offered, you know, it's a bit of a two-way, I would suggest. We were working really closely with the Chief Scientific Officer for Health, with the NHS delivery group who were looking at the activity data for the NHS, who we tend to have those connections with. We had worked less so with the knowledge and advisory service, if I'm saying that correct.

So if we'd -- perhaps if we'd had a stronger relationship with them, we would have thought to do it. I did see the Chief Statistician for Health's evidence and the -- part of the challenge, the flip side -- so if we'd have thought, we'd have done it, but also it would've been nice for them to offer. I think it was probably incumbent on both parts.

But the challenge, though, is data's only as good as it being populated at source, and we had some real challenges on that for health and social care, so --

Q. Understood.

A. -- there's some human behaviours in there.

Q. I'll just move on, because I've got one final question and I'm conscious of the time.

Last week, again, we heard from Dr Chris Williams and he said that he was aware that asymptomatic transmission could be as great as 40%, and this is following the Diamond Princess cruise ship data, and he

said he couldn't recall whether he told the Welsh Government but his main role was to keep Public Health Wales updated.

Were you aware, was Public Health Wales told about Dr Williams' awareness of possible asymptomatic transmission in late February and, if so, what steps were taken by Public Health Wales in relation to that?

A. Yeah, again, I think Quentin would be closer to it. I wasn't part of the incident management team. I can't imagine Chris wouldn't have shared that, I would have thought, because we're -- everyone shares the evidence because it would be -- you know, there's a duty to. I would have thought -- although I didn't attend the incident management team, which was a national incident management team -- that, not just this but anything that came through, there'd have been a discussion at various times, because it was an evolving picture around asymptomatic transmission, that that would have been discussed and debated at the incident management team; and any other further evidence that came through, I would have thought that would have been debated there.

MS FOUBISTER: Thank you.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed.

Ms Jung, that completes the evidence for today?

MS JUNG: It does, my Lady.

LADY HALLETT: Thank you very much indeed, Dr Cooper, very grateful.

I'm afraid I'm not sure I can give you a guarantee that you won't be asked to help again. I'll try to limit it. I do understand the impositions that asking people to give evidence makes upon them, apart from anything else providing the statements and things, but we're very conscious of it and will only call on your help if we need it.

So thank you for what you've done so far.

THE WITNESS: Of course. Thank you.

(The witness withdrew)

LADY HALLETT: 10 o'clock tomorrow, please.

(4.12 pm)

(The hearing adjourned until 10 am on Wednesday, 6 March 2024)

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