

Tuesday, 5 March 2024

1
2 (10.00 am)
3 **MR POOLE:** Can I call Dr Andrew Goodall.
4 **DR ANDREW GOODALL (sworn)**
5 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2B**
6 **MR POOLE:** If you could start, please, by giving us your
7 full name.
8 **A.** Bore da, good morning, I'm Andrew Goodall.
9 **Q.** Dr Goodall, if I can ask you whilst you are giving your
10 evidence just to keep your voice up so we can hear you,
11 but also, importantly, so your evidence can be recorded.
12 If I do ask you a question you don't understand, please
13 ask me to rephrase it.
14 Thank you for attending today and assisting
15 the Inquiry. You have kindly provided a total of five
16 witness statements to this module. The first witness
17 statement, dealing with the Welsh Government, is dated
18 21 September 2023. The second witness statement,
19 dealing with the Welsh Treasury, is dated
20 22 September 2023. Your third witness statement deals
21 with the Health and Social Services Group, and that's
22 dated 29 September last year. Your fourth witness
23 statement deals with the NHS in Wales and is dated
24 4 December last year. And then your fifth witness
25 statement, which is your personal witness statement, is

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1 then in September 2021 you were appointed to the role of
2 the Welsh Government permanent secretary. You took over
3 that post in November 2021, taking over from
4 Dame Shan Morgan, who we heard from yesterday afternoon.
5 Is all of that correct?
6 **A.** Yes.
7 **Q.** Dr Goodall, although you are currently the
8 permanent secretary to the Welsh Government, the focus
9 of my questioning this morning will be on your role as
10 director general of the Health and Social Services and
11 also chief executive NHS Wales during the pandemic.
12 If I can start then with some questions about those
13 two roles, I will come on to the responsibilities of
14 both of those roles in a bit more detail a bit later on,
15 but can you just explain to us how it came to be that
16 you held both roles at the same time?
17 **A.** In Welsh Government the NHS Wales chief executive role
18 is also the director general of Health and Social
19 Services, so it's a role that is located in the civil
20 service, but it has the responsibilities for the NHS
21 through leadership and oversight responsibilities.
22 Within that role it's really important to say that
23 the director general responsibilities are supporting
24 ministers of course, but it means that the NHS in
25 practical terms is line managed by Welsh Government.

3

1 dated 8 January of this year.
2 Each of those statements is signed by you with
3 a statement of truth. Can you confirm that the contents
4 of each of those statements is true to the best of your
5 knowledge and belief?
6 **A.** Yes, I can confirm that.
7 **Q.** You've also kindly provided three witness statements to
8 Module 1 of the Inquiry and you also gave evidence in
9 Module 1 on 3 July 2023. That's correct, isn't it?
10 **A.** That's correct.
11 **Q.** I think it would be fair to say, Dr Goodall, you have
12 gone above and beyond to provide us with as much
13 information as you possibly can about the workings of
14 the Welsh Government and, importantly for us this
15 morning, the NHS in Wales, for which we are very
16 grateful.
17 In terms of your professional background, you have
18 a law degree from Essex University, a PhD in health
19 service management from Cardiff Business School,
20 Cardiff University; is that right?
21 **A.** Yes, that's correct.
22 **Q.** Between 2009 and 2014 you were the chief executive of
23 the Aneurin Bevan University board. Since June 2014 you
24 have been the director general, Health and Social
25 Services and also the chief executive, NHS Wales, and

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1 **Q.** So would it be right in saying that the NHS Wales role
2 is essentially an outward facing role whereas the
3 director general role is primarily inward facing?
4 **A.** Yes, that's right. I oversaw all of the health
5 organisations in Wales, but in many respects I acted as
6 the NHS voice and I would have been speaking,
7 for example, more publicly on a range of areas in that
8 NHS role and then internally looking to support
9 ministers in their advice.
10 **Q.** I'd like to ask you now about the structure and the
11 operation of the NHS in Wales. Now, as we all know,
12 healthcare is obviously a devolved matter, so as
13 a consequence of that the Welsh Government has
14 overarching responsibility for the NHS in Wales; that's
15 right, isn't it?
16 **A.** Yes, that's correct.
17 **Q.** So in practical terms during the pandemic did this mean
18 that decisions concerning and impacting the NHS in Wales
19 were taken by the Welsh Government without having to
20 have recourse to Westminster?
21 **A.** Yes, they were taken at Welsh Government level.
22 **Q.** Can we, please, look at INQ000177485.
23 This is a, as it says at the top, governance map of
24 NHS Wales. Just before we start looking at this map,
25 I'm right in saying there's no legal entity called

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1 NHS Wales, is there? That's really a shorthand to
 2 describe a number of different entities that all
 3 comprise the NHS in Wales?
 4 **A.** Yes, NHS Wales is established through the 12 statutory
 5 organisations that exist, but because of the line
 6 management responsibilities of Welsh Government, it is
 7 a shorthand description.
 8 **Q.** If we focus then on the top half of this page, we see
 9 right at the very top the Welsh Government, we see the
 10 director general, chief executive role to the left. We
 11 then see the minister with responsibility for Health and
 12 Social Services, so that's Mr Gething at the start of
 13 the pandemic and later Eluned Morgan, and we see the
 14 Health and Social Services Group, which we'll hear a bit
 15 more about later about in your evidence.
 16 Below that we have three NHS trusts, seven health
 17 boards, two special health authorities, which again, as
 18 shown in this diagram, are collectively known as the NHS
 19 bodies.
 20 Those bodies and those who they contract with to
 21 provide a range of primary and secondary and tertiary
 22 care and community services, that is what, as you've
 23 just described, comprises the NHS in Wales?
 24 **A.** Yes, that's correct.
 25 **Q.** In terms of funding, the NHS Wales is funded by the

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1 the Health and Social Services Group. Can you perhaps
 2 sensibly start with just tell us, what is the Health and
 3 Social Services Group?
 4 **A.** The Health and Social Services Group is one of the
 5 departments within Welsh Government. We organise
 6 ourselves around ministerial responsibilities and
 7 portfolios. It means that we are able to divide up the
 8 civil servants in Welsh Government, and allow ourselves
 9 to give appropriate support and advice to ministers.
 10 Obviously there are individual directors and teams
 11 who sit within that group as well and they have their
 12 own individual responsibilities also, but fundamentally
 13 it's about supporting ministers in the role, and in this
 14 case it was the health minister, who of course, as
 15 you've said, was Vaughan Gething at the time.
 16 **Q.** So as well as providing a sort of leadership role for
 17 the NHS, does it provide a link also between the NHS
 18 bodies that we've just been looking at and the Welsh
 19 Government?
 20 **A.** Yes, it acts as an immediate contact point, so
 21 irrespective of my own NHS Wales chief executive role,
 22 you would find civil servants interacting very regularly
 23 and daily with a range of organisation, in Wales and
 24 indeed professional bodies as well. So it was to bring
 25 together that understanding in health intelligence in

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1 Welsh Government; is that right?
 2 **A.** Yes, correct.
 3 **Q.** What is the role of the NHS Wales executive board? Now
 4 I think it's known as the NHS Wales leadership board.
 5 **A.** Every organisation has its own statutory
 6 responsibilities, the NHS executive board was a way in
 7 which I was able to bring colleagues together from
 8 across the NHS, the chief executives of those individual
 9 bodies, alongside my own internal director team sitting
 10 within the Health and Social Services Group. So it
 11 allowed us to have an oversight role on the system
 12 leadership and to bring the collective understanding of
 13 delivery and actions across Wales together. It also
 14 allowed us the time to, whilst recognising operational
 15 issues, look forward for the NHS in Wales and make sure
 16 that we had future plans and strategies.
 17 **Q.** What duties does NHS Wales have in respect of the public
 18 sector equality duty and completing equality impact
 19 assessments?
 20 **A.** There's a duty for Welsh Government on equality impact
 21 assessments, but every organisation would also have its
 22 own equality responsibilities under that legislation, so
 23 the 12 individual health organisations would have their
 24 own responsibilities too.
 25 **Q.** I move on to next your role as the director general of

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1 Wales and to use that to support our policymaking.
 2 **Q.** In your personal witness statement you list your many
 3 responsibilities as director general of the HSSG during
 4 the pandemic. If I may, just to highlight a few that
 5 are of direct relevance to this module, is it right that
 6 you were responsible for enabling intergovernmental
 7 decision-making for health and social care?
 8 **A.** Yes.
 9 **Q.** Overseeing how health and social care policy decisions
 10 were made, communicated and implemented?
 11 **A.** Yes.
 12 **Q.** Overseeing the availability and use of data and evidence
 13 in decision-making?
 14 **A.** Yes.
 15 **Q.** Overseeing preparedness, NHS capacity and the ability to
 16 increase capacity and resilience?
 17 **A.** Yes.
 18 **Q.** And overseeing the pandemic response in all health
 19 settings, so that includes in respect of infection
 20 prevention, control, triage, critical care capacity,
 21 patient discharge, the approach to palliative care,
 22 workforce testing and inspections?
 23 **A.** Yes.
 24 **Q.** And you also contributed to evidence which informed
 25 decisions on the use of lockdowns and other NPIs?

8

1 A. Yes.

2 Q. In your role as director general, you were also part of
3 the permanent secretary's senior team. Did this bring
4 any additional benefits to discharging either of your
5 roles as director general or chief executive of the NHS?

6 A. Given that I was located in the civil service and
7 a director general, it meant that I was able to bring
8 conversations about health into the wider Welsh
9 Government structures, so working alongside my other
10 director general colleagues, also working in support of
11 other ministers, so there were genuinely advantages
12 about being part of that senior leadership team. But
13 I did have to look outward to the NHS and provide
14 support there, but it also meant that I was able to
15 access support and indeed support others within the
16 Welsh Government team too.

17 LADY HALLETT: Can I just interrupt? You're both going very
18 quickly and I don't want to end up with complaints from
19 the stenographer.

20 MR POOLE: My Lady, I will try to slow down my questions.
21 Dr Goodall, what was the relationship between
22 yourself and the Minister for Health and Social
23 Services?

24 A. I reported directly to the Minister for Health and
25 Social Services in respect of my oversight of the NHS

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1 was Frances Duffy, who is listed on your screen, the
2 director of Primary Care and Innovation.

3 Q. Taking them in turn, perhaps dealing with Dr Atherton
4 first, can you briefly describe your relationship with
5 Dr Atherton throughout the pandemic, specifically in
6 your capacity as director general?

7 A. Frank had a lead role as our Chief Medical Officer.
8 I was always mindful that he had a Cabinet adviser role
9 irrespective of the line management to myself, so that
10 afforded him a different level of contact within the
11 organisation. I was his line manager, so I was there to
12 support the role of the population health team, and
13 Frank and I had very regular contact, both individually
14 and collectively, as you would expect, through the
15 pandemic. Often many times through the day. Often we
16 were located working within our Cathays Park offices
17 with the very limited staff that were available as well.
18 But it was a very frequent contact, as you would expect,
19 with Frank.

20 Q. And Dr Orford, your contact and relationship with him
21 during the pandemic?

22 A. So through the pandemic it was very much enhanced from
23 my previous contacts with Rob, which would have happened
24 through his previous role, but of course given the
25 extraordinary role that he discharged for us through the

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1 and my director general responsibilities, so he was my
2 lead minister. It meant that I had frequent daily,
3 sometimes throughout a day, contact with the minister,
4 and it was an important relationship to be able to
5 respond to his requirements and make sure that my policy
6 teams were supporting ministers appropriately.

7 Q. If we can, please, have on screen INQ000083227. I'm
8 grateful.

9 This is an organisational chart with which the
10 Inquiry is now very familiar. We can see you as one of
11 the four director generals. Below you we can see the
12 prominent individual within the HSSG. We see the CMO,
13 Dr Atherton, sits within the HSSG.

14 Not shown on this chart, did the Chief Scientific
15 Adviser for Health, so Dr Orford, did he sit within the
16 HSSG?

17 A. He was located within the Health and Social Services
18 Group in a deputy director role prior to the pandemic.

19 Q. And the CMO and the Chief Scientific Adviser for Health,
20 who were they accountable to?

21 A. The Chief Medical Officer was accountable to myself.
22 Frank also had a director of health protection role
23 sitting in my structures. The deputy director role,
24 which was the Chief Scientific Adviser for Health,
25 reported to one of my directors, so pre-pandemic this

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1 pandemic response I saw Rob, again, very frequently,
2 including around collective meetings like Cabinet and
3 other collective meetings of civil servants, but also
4 that gave me a change to be supporting Rob in his
5 individual role as the Chief Scientific Adviser for
6 Health.

7 Q. Now, Professor Peter Halligan was the Chief Scientific
8 Adviser for Wales during the pandemic and I think you've
9 said in one of your witness statements you had limited
10 contact with him. Why was that?

11 A. I had limited contact. He reported to a different
12 director general, firstly, not in the health context,
13 so -- because of the science and innovation brief. As
14 this started off as a health-led response, Rob's role
15 progressed and as we converted from that health-led role
16 we ended up using Rob actually in that more focused
17 Chief Scientific Adviser health role because it linked
18 to the understanding of the pandemic response, and he
19 discharged that very effectively through the pandemic.

20 Q. Dr Goodall, if I can ask you again, please slow down
21 your natural pace of speech, just so the stenographer
22 can capture all of your evidence. I'm sure it's my
23 fault as well.

24 In your personal statement you say this about
25 Dr Orford, you say:

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

7 And you say this:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 to the pandemic response?

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

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

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

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

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

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

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

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

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

25 But it's not only my experience of the pandemic

17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 **Q.** I understand.

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

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

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

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

23

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

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

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

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

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1 Thank you.

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

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

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

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

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

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

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

9 **A.** Yes.

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

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

25

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

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

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

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

27

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

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

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

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

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

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

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

26

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

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

18 **Q.** Perhaps we can just look at then a review that was
 19 carried out, I think it was a review from January to
 20 September 2020 and then there was a report dated
 21 25 September 2020.

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

23 If we can have a look at page 3, so the HSSG
 24 Covid-19 response structure is set out here.

25 Dr Goodall, you'll be glad to know I'm not going to ask

28

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

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

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

12 **A.** I think the actual seven groups were focused on the
13 right areas for us. I'd already highlighted myself that
14 I felt in those early stages there were some areas where
15 potentially there was duplic -- energy that was taking
16 place in the early phase. It was a very fast-moving
17 environment in the pandemic response at that time.
18 Despite the reviews that we undertook, though, we
19 retained the essence of the structure all the way
20 through, so those seven subgroups were -- remained.
21 What we tried to target was actually to make sure that
22 people were really clear of their accountability and how
23 they would interact with the different areas of
24 responsibility as well, so -- but I accept that.
25 I think in part I probably suggested some of that in my
29

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

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

6 Is that something that you recognise?

7 **A.** Yeah, I think in the early stages, as we were picking up
8 in this very fast-moving environment, we would pick up
9 issues and then be determining where the accountability
10 needed to be in place for that. As the Welsh Government
11 oversight mechanisms really initiated properly during
12 March 2020, I thought that became a lot clearer, but
13 there were at times some areas where we just simply
14 needed to call out where the responsibility was. So as
15 an example on the testing side, Test, Track, Protect was
16 put in place with a director lead who oversaw the
17 programme of testing responsibility from April 2020, and
18 that was an alteration we needed to make just a give
19 real clarity to the system.
20 **Q.** A second review was conducted by the HSSG, it was dated
21 11 October.

22 We've got that at INQ000083257.

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

31

1 answer just now.

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

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

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

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

25 **Q.** Just again staying on this document, I think it's this
30

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

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

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

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

24 **A.** They were reported up to ExCovid, so in fact the
25 response I think that you're referring to here from
32

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

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

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

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

22 Is this something that you agree with?

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

33

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

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

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

19 **A.** Indeed, yes.

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

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

35

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

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

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

18 **A.** Yes, they did.

19 **Q.** Did you attend TAG and TAC?

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

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

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

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

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

15 **Q.** What was your role within that group?

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

36

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

37

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

39

- 1 **Q.** Now, as we've touched on, one of your roles was to
2 understand and inform Welsh Government about capacity in
3 the NHS. We've heard quite a lot about data collection
4 from local health boards, how that was then analysed by
5 the knowledge and analysis service, alongside Digital
6 Health and Care Wales and also HSSG officials.
- 7 Would it be that data that you would be speaking to
8 when addressing Cabinet?
- 9 **A.** Yes, there was data generally available. Of course we
10 had had to create systems from the very start of the
11 pandemic response, and I wanted to make sure that there
12 was a consistency in the data and information that I was
13 reporting on, but I would tend to give a sit rep report,
14 a traffic light rating of the way in which organisations
15 were responding around Wales, but yes I would use some
16 core data particularly around hospital admissions and
17 critical care admissions.
- 18 **Q.** I'll come back a bit later this morning to ask you a bit
19 more about data and modelling, but in your view was
20 capacity of the NHS and ensuring that it would not be
21 overwhelmed, was that the main priority of the Welsh
22 Government's decision-making throughout the pandemic?
- 23 **A.** It was certainly important during the first and second
24 waves. I think the balance changed later on in the
25 pandemic response, particularly when we had the benefits

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

40

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 **A.** Yes.

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

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

23 It starts:

24 "FA ..."

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

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

5 Did work on isolation begin at this stage, as
6 recommended by the CMO? Just to remind you, this is
7 21 January 2020.

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

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

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

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1 level, it was Frank's letter, I think it was of
2 5 February, that was actually putting in a formal
3 requirement for the isolation and tracing, so from that
4 perspective the formal ask into the system was there.

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

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

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

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

19 **LADY HALLETT:** Thank you.

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

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

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

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

17 **A.** Please.

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

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

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

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

13 So these planning assumptions were being given
14 a couple of weeks after the first Covid case in England,
15 which was 29 January, but at this point in Wales there
16 had not been a case. That was to come later on, on
17 28 February. So Wales, it might be said, was in the
18 unique position of having no confirmed cases at this
19 stage but being privy to these planning assumptions.
20 What steps were you taking at this stage prior to there
21 being confirmation of a positive case in Wales?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **LADY HALLETT:** Sorry to interrupt.

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

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

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

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

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

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

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1 on decisions that might need to be taken in response to
 2 the pandemic?
 3 **A.** The planning and response cell had a social care
 4 subgroup, and that was the focus of our engagement with
 5 the care home system. It allowed us to understand their
 6 assessment of issues, also to raise any concerns and
 7 areas, often where they were seeking, of course, to know
 8 what the evidence and the support that would be made
 9 available to them was. So yes, there were mechanisms
 10 for that ability. And equally there was an opportunity
 11 for ministers to be engaged as well. But the planning
 12 and response cell was a good starting point, I think.
 13 **Q.** The day after confirmation of the first case in Wales,
 14 so that was the 28th, so we're now talking about
 15 29 February, you emailed Tracey Cooper of Public Health
 16 Wales and you said it "would be useful to just keep in
 17 touch on levels of contact and calls you were fielding
 18 given your enhanced arrangements", and then there was
 19 a response that she would keep you in touch and asked if
 20 it would help if she'd give you a daily status report,
 21 to which you responded:
 22 "Yes that would help ... [Document read] ... a feel
 23 for public concerns and pressures on your teams and the
 24 system."
 25 Just help us, what information were you seeking from
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1 reasonable worst-case scenarios, so you say:
 2 "In March 2020, modelling for NHS Wales projected
 3 a necessity for 900 critical care and an additional
 4 10,000 system-wide beds at the point of peak demand. It
 5 should be borne in mind that the existing capacity
 6 within NHS Wales was only 152 critical care and
 7 7,839 system-wide beds as at the end of January 2020.
 8 This scenario was based on a 40% reasonable worst case
 9 scenario and, given the then rate of transfer, it was
 10 anticipated that Wales would see peaks in demand over
 11 the next 3-4 weeks. This reasonable worst case scenario
 12 modelling indicated that NHS Wales' capacity would be
 13 significantly exceeded, as over half the population of
 14 Wales would become symptomatic, with a high proportion
 15 of those contracting the virus requiring hospital care,
 16 including ventilation, and serious infection resulting
 17 in excess deaths."
 18 My question is this, Dr Goodall: wasn't this obvious
 19 from the SAGE planning assumptions that we have just
 20 looked at in February?
 21 **A.** I don't -- I don't think this was obvious at the time,
 22 and in respect of our pandemic flu plans and some of the
 23 experiences that we'd been through in both previous
 24 exercises but also in swine flu, we wanted to make sure
 25 that our response was proportionate, so whatever the ask
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1 Public Health Wales at this stage, at the end of
 2 February, and did you get what you wanted?
 3 **A.** Yeah, Public Health Wales had been very plugged in from
 4 January in terms of helping us with the understanding of
 5 the progress of the virus, and that carried on through
 6 February. It was very much tied into the updates that
 7 would go up to ministers. All I was really asking for
 8 from Tracey at that stage was I was aware of the
 9 intensity and the growing activity that they were
 10 undertaking in their tracing service and I just wanted
 11 to have some informal understanding from her about how
 12 that was going to give her some support for her team.
 13 I'd visited the team as well to understand their
 14 response as well, and so it wasn't really about
 15 an alternative data source, it was more just checking in
 16 whether there was anything that was worth me knowing,
 17 because Tracey is an accountable officer and chief
 18 executives in Wales reported to me.
 19 **Q.** As we move into March, I'd like to just show you
 20 a paragraph in your -- I think it's your personal
 21 witness statement, so it's INQ000396873,
 22 paragraph 303 -- thank you very much.
 23 And I think this is in answer to a question I asked
 24 a moment ago. You've described this really as the
 25 trigger point. This is when you were discussing
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1 was and however the virus was progressing, that we were
 2 keeping in line with that.
 3 I think it was significant that the first case in
 4 Wales was on the 28th and that acted in itself as
 5 a trigger. But the reasonable worst-case scenarios,
 6 there is a danger of seeing them as the forecast, that
 7 they are likely and that they will happen. In fact our
 8 swine flu experience told us different. You know, our
 9 reflections after that event was that we couldn't rely
 10 necessarily on the reasonable worst-case scenarios and
 11 go for it. I think the reality for us in March, though,
 12 was that the data that we were seeing progressed both
 13 internationally and on a UK basis was genuinely showing
 14 that the exponential growth and showing that the
 15 reasonable worst-case scenario was actually possible,
 16 and I think it was that realisation that of course
 17 changed the extent of our planning at that time.
 18 There was a very different mood of the NHS system in
 19 early March, based on this exercise, but also based on
 20 the experiences that we were seeing internationally as
 21 well.
 22 **Q.** I mean, leaving reasonable worst-case scenarios to one
 23 side, would you not agree that -- was it not clear by
 24 29 January 2020, when the first cases were detected in
 25 the UK that the virus is now here, it's in the UK, and
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1 in all likelihood there was no way of preventing it
 2 spreading to Wales?
 3 **A.** I don't think that was obvious to us in all of the
 4 intensity of what we were going through at that time.
 5 We were making judgements based on those assessments,
 6 "very low" to "low", "low" to "moderate", and making --
 7 to have judgements. In hindsight, of course that is the
 8 case, about wishing to have responded earlier, given the
 9 impact the virus had globally as well as of course in
 10 the UK, but at that time we were looking to progress in
 11 line with our planning, and seeing how we could respond
 12 to the assumptions as they emerged as well.
 13 **Q.** At what stage do you say it became clear in Wales that
 14 if more action was not taken the NHS would simply be
 15 overwhelmed? Was it at this point in time, when you
 16 were carrying out these reasonable worst-case scenarios?
 17 **A.** There was definitely a switch from the last week of
 18 February into that first week of March, and through
 19 a variety of different sources, including the contact
 20 with the NHS, where that felt suddenly very different
 21 and the need to step up those responses as well.
 22 **Q.** If we could, please, have a look at some minutes,
 23 an ExCovid meeting of 10 March. It's INQ000320939. If
 24 we can -- thank you -- have a look at page 2, and it's
 25 paragraph 2.4.

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1 were already in that week starting to ask the NHS what
 2 are the kind of things that would allow you to free up
 3 time to prepare, and I think this was probably
 4 a reflection of routine activities.
 5 **Q.** I think you said February 2022 about updating extreme
 6 surge guidance. You obviously mean February 2020?
 7 **A.** Sorry, February 2020, yes, thank you for that.
 8 **Q.** Was there a discussion at this stage about who would
 9 take such decisions? Would this be an individual
 10 medical professional who is providing care to a patient,
 11 or was this a ministerial decision?
 12 **A.** I think at this stage it was seen that it would be
 13 an area for individual clinicians, that's the strength
 14 of the NHS as a system, is to make the right decisions
 15 for patients. I think it was a recognition that there
 16 would be a requirement for us to put in place particular
 17 criteria. And I remember as an example, if I could just
 18 share it, that we had done some work through the Chief
 19 Nursing Officer in Wales just to make sure that criteria
 20 that may need to be used in critical care for nursing
 21 staff ratios, that they were owned by us nationally, so
 22 that there was support for what was going to be done on
 23 a local basis as well.
 24 But there was definitely a need for us to recognise
 25 that, in the worst examples, we may need to step in with

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1 I think we're picking it up in the fifth line, yes:
 2 "Andrew Goodall added that if there is a change
 3 ... [Document read] ... likely to be those who stands to
 4 gain the most."
 5 Was there thinking by this stage, so this is
 6 10 March, that choices may need to be taken about which
 7 patients received critical care and which didn't?
 8 **A.** It wasn't necessarily a choice at that time, but very
 9 much tied into this week were the planning arrangements
 10 for the stepping down of -- or the potential stepping
 11 down of actions and services in Wales, so routine
 12 activities, operations taking place, and that came to
 13 a culmination at the end of the week on 13 March. That
 14 in itself would mean that there would be a priority for
 15 emergency patients going into critical care rather than
 16 routine patients if we went down that decision.
 17 However, in February 2022(sic), in the background of
 18 our arrangements, we had been updating extreme surge
 19 guidance just as part of emergency planning. It was
 20 updated again in April. Throughout the whole of the
 21 pandemic response we never had a need to introduce that
 22 emergency surge guidance, but it would have given
 23 criteria to services in Wales in the most difficult of
 24 circumstances to make choices, and that wasn't necessary
 25 at this time. But I think this was a reflection that we

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1 that very kind of salutary and significant advice.
 2 Didn't feel that it was advice that ministers needed to
 3 direct but it was advice that ministers needed to be
 4 aware of.
 5 **Q.** On 12 March you attended a meeting with the NHS Wales
 6 chief executives to discuss urgent action needed to be
 7 taken to protect the NHS. We've got an email from
 8 Tracey Cooper the same day, it's -- I'm grateful, it's
 9 already on the screen.
 10 Helpfully, if you have a look at point 6 of that
 11 email, and particularly the third line, if I can pick it
 12 up from there:
 13 "There is also a unanimous view from the COOs on the
 14 call that now is a compelling time -- both operationally
 15 and clinically on the basis of minimising exposure of
 16 current admitted patients in clinical settings to
 17 increasing COVID-19 patients, to free up capacity on
 18 elective, OPAs, discharging people, clarity around
 19 primary care services etc to enable people to rapidly
 20 implement capacity plans, prioritise clinical services
 21 and enable clinicians to prepare for what is to come
 22 which has apparently been an ask of anaesthetists and
 23 other clinicians in the system. The ask was for
 24 a decision to be made tomorrow (Friday) to proceed on
 25 this basis."

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

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

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

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1 framework?

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

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

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

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

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

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

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

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

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

25 **Q.** Was the care sector in Wales consulted on this

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

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

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

11 **LADY HALLETT:** Certainly.

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

14 **(11.15 am)**

15 **(A short break)**

16 **(11.30 am)**

17 **LADY HALLETT:** Mr Poole.

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

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

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1 sponsorship.

2 **Q.** You say in your evidence about the press conference
3 announcing that framework of actions, you say:
4 "I recall that this press conference was very
5 visible in Wales and caused some shock among the
6 population."
7 Do you think it caused shock because the public were
8 unaware perhaps up to this point in time just how
9 serious the threat posed by Covid was in Wales?
10 **A.** I think it was a shock in part for that reason, although
11 there was some sense in Wales that, in the context of
12 the international experiences that we were seeing, we
13 could see some parts of the population starting to act
14 differently. I think the thing that stuck out for me,
15 though, was that it was the first time that we had put
16 the figures into the public domain about the likely
17 impact in terms of what it would mean, not least deaths
18 in Wales, and the health minister chose to do that as
19 part of the press conference, felt it was really
20 important that that was understood.
21 **Q.** Do you think this should have been something done
22 earlier? Do you think it could have been better managed
23 throughout February and March so it didn't come as such
24 a shock on 13 March?
25 **A.** I think I'd go back to some of my earlier comments where
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1 and to understand some of those impacts in a different
2 way, but at the time it was also to do something that
3 was in line with the feeling and the evidence that was
4 coming from the NHS itself, and it was really clear in
5 that first week of March that the NHS felt that we were
6 at a different position for planning and preparation.
7 **Q.** Now, one of those directions, I just want to focus on,
8 which is expedite discharge of vulnerable patients from
9 acute and community hospitals, now we know there was
10 a lack of testing in the early stages of the pandemic
11 and the Welsh Government then took decisions about
12 prioritisation of testing, and we'll come on to that
13 a bit later in your evidence. We also know that there
14 was a period during which asymptomatic people were being
15 discharged from hospitals into care homes without
16 a test. Was this direction, to expedite the discharge
17 of vulnerable patients from hospital, was that
18 a ministerial decision?
19 **A.** That was a ministerial decision in line with the advice
20 that had come up through the system. It was intended to
21 do two things: it was intended to help the NHS to create
22 capacity, because it would have meant that there were
23 patients who were ready for discharge who could be cared
24 for in alternative environments; but the wording of the
25 actions as well was to try to provide support for
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1 there are constraints on us about what can be reported,
2 when and how. Things that come through the COBR
3 mechanisms of course have a level of confidentiality
4 around them. I think -- looking backwards, I think it
5 would have helped to have been able to be more
6 transparent with the population, certainly through March
7 and maybe at the end of February, but at that time that
8 was a judgement that the minister made at the time and
9 I do think it was the right one.
10 **Q.** Now, that framework of actions we saw a moment ago,
11 those ten points within that framework of actions, they
12 were all within the competence of the Welsh Government,
13 they were all devolved decisions to be taken
14 independently of the UK Government, so the Welsh
15 Government didn't have to wait for the first Covid case
16 to come to Wales before taking those steps, nor did it
17 have to wait for pandemic status to be announced by the
18 WHO. I mean, generally speaking, had those steps been
19 taken earlier, do you think they could have been
20 undertaken in a safer way?
21 **A.** In hindsight I would say safer. They were themselves
22 an extraordinary and unprecedented set of actions that
23 we had never done before in the NHS, so from that
24 perspective they were of really great significance.
25 Looking backwards, they may have helped us to mobilise
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1 vulnerable people in those settings, because it was
2 trying to move them to what we hoped was a safer
3 environment.
4 It was inevitable that the hospitals were going to
5 become the focal point for admissions and the growth of
6 Covid, and we were looking to try to find a way of
7 ensuring that those individuals were also supported as
8 well. But first and foremost it was about how we
9 created capacity for the Welsh NHS.
10 **Q.** Now, concerns seem to have been raised relatively
11 quickly by the local health boards.
12 If we can see an email, it's INQ000262195, it's an
13 email sent by your private secretary on 18 March. If we
14 just focus in on point 1, please:
15 "Care home sector approaches to admissions -- Albert
16 has taken up the concerns raised including ... [Document
17 read] ... last Friday was about expedited discharge of
18 vulnerable patients."
19 Again, a question I asked a moment ago: had the
20 decision been taken to start expediting the discharge of
21 vulnerable patients even a few weeks earlier, do you
22 think that would have allowed for more safeguards?
23 Would it have been appropriate to have put in more
24 safeguards and ultimately save lives at this point in
25 time?
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1 A. At the time we were responding to the progress of the
2 virus and the discussions with the NHS about supporting
3 it to prepare. With everything that we know now about
4 the pandemic response and looking back, that would have
5 helped us, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 "The care sector ..."

23 If I pick it up fourth line it says:

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

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

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

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

11 We can see it at INQ000083241.

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

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

15 "ii COVID Hospitalisations."

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

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

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

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

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1 of these reporting arrangements.
2 It was really helpful that we had our knowledge and
3 analytical service that was able to act as the quality
4 guardian for some of that data.

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

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

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

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

23 I think, picking up on your previous answer --

24 **A.** Yeah.

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

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

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

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

11 **LADY HALLETT:** No, no, in normal circumstances.

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

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

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

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

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

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

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

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

25 In my own experience we were able to actually use

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

6 **LADY HALLETT:** So that is now in operation?

7 **A.** We have got --

8 **LADY HALLETT:** And has lasted since the pandemic?

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

13 **LADY HALLETT:** Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 you a few questions about shielding.

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

7 **A.** Yes, that's correct.

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

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

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

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

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

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

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

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1 representatives of ethnic minorities in Wales.

2 **Q.** Now, I think that letter from Professor Singhal, that's

3 a letter of 17 April.

4 **A.** Correct.

5 **Q.** We heard something about it in the first week of

6 evidence. There was also a letter from Race Council

7 Cymru at about the similar time.

8 You explain in your witness statement that it was

9 1 May that you endorsed the use of an existing risk

10 assessment tool developed by the Aneurin Bevan

11 University Health Board as an immediate way forward. We

12 obviously heard evidence, the Inquiry heard evidence,

13 last week from Professor Ogbonna that there was work

14 being carried out in respect of a risk assessment tool

15 that was then presented in late May, and I think it was

16 then rolled out on 27 May.

17 I mean, do you have any comment on the fact the

18 Aneurin Bevan health board had managed to create its own

19 risk assessment tool in April and yet the Welsh

20 Government's commissioned risk assessment tool wasn't

21 finalised until 27 May?

22 **A.** I think what I wanted to do at the time was to make sure

23 that the group, who were a group of experts that we drew

24 together, had urgent but sufficient time to do the work.

25 The reason for my intervention on 1 May was that I gave

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1 access. As an aside sos announcing Ppe is available for

2 all social care is different from our position -- we

3 have issued PPe from pandemic stocks to supplement local

4 supply to be everywhere in wales by Monday

5 geographically distributed -- our calculations are that

6 there are finite supplies for the weeks ahead that if we

7 don't have some order in use, would without

8 replenishment at uk level run out -- so we need to

9 ensure that thresholds for use are maintained.

10 "The process feels more and more like announcing

11 a concept and working back ASAP in detail and

12 practicalities -- this reflects the speed of events has

13 meant that some of the spirit of sharing has been

14 disappearing so we are finding it happening less simply

15 on speed of decision making and announcements."

16 So this is 20 March, did you have concerns that

17 there may come a point in time at which PPE would simply

18 run out in Wales?

19 **A.** Generally that was a concern. We reported as such in

20 the public domain as well. I even recall a press

21 conference where I was asked about supplies that were

22 left, and I think I very openly said that we were within

23 a few days of some individual items at the time. That

24 was later in April.

25 I think the pandemic stocks that we'd put in place

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1 a national direction to all of the health organisations

2 to start using that risk assessment. One of our

3 advantages in Wales is that we could pick up these local

4 templates and try to use them to expedite.

5 So there was a delay but that was a reason why

6 I wanted to make sure that the risk assessment was

7 generally available. I do think the work that

8 Professor Singhal and his colleagues did was really

9 exemplary in an urgent context. Its use has been very

10 significant, not just for the NHS and care system in

11 Wales but beyond, and I think ending up with probably

12 about 130,000 uses of the individual risk assessment,

13 you know, and it stayed very similar to that initial

14 version, has been really important to the pandemic

15 response all the way through, and gave confidence.

16 **Q.** Change topic again and ask some questions about PPE,

17 please.

18 If we could have on screen INQ000303227. This is

19 a WhatsApp group you were in with Shan Morgan,

20 Dame Shan Morgan, Andrew Slade, Tracey Burke. If we can

21 go to page 5, right down at the bottom of that page

22 there's an email -- sorry, there's a WhatsApp. It's

23 20 March. This is from you, just read it:

24 "Probably worth reflecting on still a public

25 discussion on Ppe -- shortages and who to use and

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1 as a contingency allowed us to manoeuvre our way through

2 those first weeks with around 10 million items that had

3 been made available. But absolutely, we needed to

4 ensure that there was a good supply chain in order and

5 we were able to achieve that.

6 My role was really to secure that supply at

7 a national level, but what we also had to do is very

8 much change the way in which we were issuing supplies

9 across Wales, literally to thousands of sites, rather

10 than the few hundred that would have been the reality

11 for the NHS in Wales.

12 **Q.** Now, PPE was something that was raised by the BMA Cymru

13 on 22 March 2020.

14 INQ000118526, if we could have that, thank you very

15 much.

16 So this is an email, in fact a response to an email

17 that you had sent about shielding. However, as we can

18 see under the heading at the top, "PPE", the BMA say

19 that before they list their comments on the shielding

20 letter they must raise the issue of clarity on PPE

21 guidance for GPs and other doctors/healthcare

22 professionals. So if we're looking at the second

23 paragraph, second line:

24 "Whilst I do not feel a public dispute on this would

25 be helpful in Wales, we ... [Document read] ... in line

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1 with the WHO guidance and latest research ..."
 2 So there's a clear suggestion there from the BMA
 3 that PPE was not being supplied and guidance not being
 4 given in line with WHO guidance. Is that something you
 5 agree with?

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

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

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

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

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

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

20 You go on to say:

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

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

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

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

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

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

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

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

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1 available tests."

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

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

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

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

25 Maybe to give a comparison about the early phase, if

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

7 **Q.** Who decided who should be prioritised for testing?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 perspective?

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

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

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

16 "On hospital admissions for Covid-19, these are
17 at 550, double on that of a fortnight ago. These are
18 not yet at the level seen in March and April but the
19 infection rate needs to stabilise within the next 2 to
20 4 weeks or we will see hospitalisations exceed the
21 figures from earlier in the year."

22 By the time of the next ExCovid meeting,
23 13 October -- if we can see those minutes, please,
24 INQ000221045 -- if we can have a look, please, at
25 page 2, paragraph 2.1, your update here was that:

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

5 **Q.** The firebreak, as we know, came into force in Wales on
6 23 October. In your view, was that the right time for
7 the firebreak?

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

19 Having said that, the firebreak was a really
20 important intervention. It was more limited than maybe
21 ministers had wanted from their discussions around the
22 table, but I do think the firebreak had the impact that
23 was broadly intended because it reset the virus by about
24 38 days.

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

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1 "There [were] just over 700 patients in hospital
2 with Covid-19, this is a 50% increase in the last
3 7 days."

4 And then in paragraph 2.3:

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

9 Finally, paragraph 2.4:

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

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

17 **A.** I was sharing from a factual perspective the information
18 about the NHS, whilst the NHS wasn't seeing numbers that
19 were like the peak that we'd seen in April. You can see
20 from the two examples that you've given how it was clear
21 that there was exponential growth happening, for that
22 50% increase over a seven-day period was really
23 important, so I wanted to make sure that there was
24 an understanding of what that meant.

25 NHS capacity was available to accommodate those

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

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

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

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

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

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

10 **LADY HALLETT:** Yes, Ms Harris.

11 **Questions from MS HARRIS**

12 **MS HARRIS:** Good morning, my Lady.
 13 Good morning, bore da.

14 **A.** Bore da, good morning.

15 **Q.** I appear on behalf of Covid-19 Bereaved Families for
 16 Justice Cymru. I would like to ask you some questions
 17 about PPE workstreams, and specifically with regards to
 18 the Covid-19 health countermeasures group, which you've
 19 referred to in your evidence as having the role of
 20 operational co-ordination and oversight of the Welsh
 21 Government's pandemic health countermeasures for PPE,
 22 consumables and medicines, and that the group monitored
 23 distribution arrangements as well as identified and
 24 resolved issues associated with supply.
 25 Before I get to the question, if I could highlight

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

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

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

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

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

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

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1 some points in the evidence. First of all, the evidence
 2 provided by Mr David Goulding that he chaired this group
 3 and that the first meeting of the group was on
 4 12 February 2020, and I'd like to ask for this document,
 5 please, to be produced up: INQ000298968, which is
 6 an email dated 20 February, if that could come up on
 7 screen.

8 Thank you.

9 That is an email noting the action points arising
 10 out of that first meeting of the group on
 11 12 February 2020, and if I could take you to some of
 12 those action points, for example, first of all,
 13 action 2:
 14 "GD to provide a list of the six PPE products
 15 required for Coronavirus."
 16 Action 3:
 17 "DG to raise at the Clinical Countermeasures Board
 18 Coronavirus sub group the absence of long cuff gloves,
 19 visors and fluid resistant gowns in the stockpile."
 20 Action 4:
 21 "HEPU to ascertain whether a [just in case]/[just in
 22 time] contract exists for the order of soap."
 23 If we could go to the next page and to action 10:
 24 "HEPU to clarify the relevant items in the Wales
 25 pandemic stockpile and communicate that information to

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1 NHS EP leads."
 2 At action 11 there's a reference to ascertaining
 3 whether there are people trained to fit test.
 4 And if we go to action 15, a number of individuals
 5 are allocated "to discuss a concept of operations".
 6 And we see there are 20 action points all in all.
 7 When considering the question I'd like to ask you
 8 about timing, I'd invite you to have in mind the
 9 landscape as it was in January 2020, because this group
 10 of course started to meet on 12 February 2020.
 11 In January 2020 we had, first of all, 16 January,
 12 that the virus was given the initial classification of
 13 HCID, high-consequence infectious disease.
 14 We know that Public Health Wales had evoked its
 15 emergency response plan at enhanced level by 22 January.
 16 On 24 January or by that time we know that the Chief
 17 Medical Officer for Wales had advised the First Minister
 18 that there was a significant risk that the virus would
 19 arrive in Wales.
 20 On 30 January the World Health Organisation had
 21 declared a public health emergency of international
 22 concern.
 23 On the 31st it was made public that two patients,
 24 they were related to each other, had tested positive for
 25 Covid in the UK, and we also know that there had been
 101

1 availability of up to 10 million PPE items which we had
 2 in storage. I think that note rightfully shows that
 3 there were areas of operational detail that needed to be
 4 worked through, and there was an urgency around doing
 5 that at the time.
 6 Pandemic flu preparation was different to some
 7 extent from some of the PPE that was required for
 8 Covid-19, and I would have expected those gaps to
 9 happen. But at the time I felt it was in line with
 10 a low impact assessment that at the time there was no
 11 evidence of it for Wales.
 12 If I was describing -- given the two and a half
 13 years that we went through later and the opportunity to
 14 set in train some of these things earlier, then that
 15 would have helped at that time, but I don't think it
 16 actually changed the nature of the way in which we
 17 distributed from the pandemic stock, for example. So
 18 that was always available to us to be secured and
 19 provided for the different sectors.
 20 **Q.** Can I just ask you, do you think it was correct to
 21 regard the situation as a low impact assessment at that
 22 time?
 23 **A.** It was the Chief Medical Officer's assessment, and we
 24 would be putting in place our actions in response in
 25 line with that at the time. So I'm responding to how it
 103

1 attendance at two COBR meetings.
 2 And on 29 January, at that COBR meeting, the UK
 3 Chief Medical Officer had said that the reasonable
 4 worst-case scenario for the virus was similar to that
 5 for pandemic influenza, which of course, as we know,
 6 signified widespread infection and many thousands of
 7 excess deaths on that scenario.
 8 So my question is: do you agree that it was obvious
 9 from the very early stage that if the virus arrived in
 10 Wales, PPE supplies were bound to be needed and quite
 11 possibly very quickly and in large quantities? And
 12 given that, do you agree -- if you agree with that
 13 proposition, do you also agree that the work that the
 14 countermeasures group was doing should have started at
 15 the very earliest opportunity and earlier than
 16 12 February 2020?
 17 **A.** From my perspective, in Wales, the introduction of the
 18 health countermeasures group was an early intervention.
 19 As I was describing earlier, the assessment at that
 20 stage and through February was that this was low impact
 21 at that time for the UK, and that drove a lot of our
 22 triggers and actions at that point.
 23 The health countermeasures group wasn't starting
 24 with a blank sheet of paper. The advantage that the
 25 health countermeasures group had was that it already had
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1 felt at the time and how we were responding. Of course
 2 the pandemic itself was an extraordinary impact on all
 3 of us in society over an extended period of time, and
 4 that was very different from how we would have been
 5 approaching those early days in respect of using our
 6 emergency preparedness.
 7 **Q.** So you wouldn't accept that there would have been any
 8 benefit from having started this work of co-ordination
 9 and oversight and the kind of actions set out in that
 10 email at an earlier stage?
 11 **A.** I think -- given what we know now, I think that would
 12 have been helpful to have worked through, but I do think
 13 that the way in which we were securing those supplies,
 14 working our way through those choices, meant that we
 15 were able to secure that national supply for Wales, even
 16 if it was under very extreme pressure at times as well.
 17 So I'm not sure it really changed the outcomes at
 18 that stage but was part of that early planning and
 19 preparation.
 20 **Q.** Can I ask you about a comment that appears in the
 21 witness statement of Mr Vaughan Gething where he says,
 22 and I'm reading a passage from page 138 of his witness
 23 statement for this module:
 24 "We underestimated how quickly the PPE ... [Document
 25 read] ... amount of our stockpile was not fit for
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1 purpose."

2 If I could ask you: does the fact, as I assume you

3 would agree is correct, that a certain part of the

4 stockpile turned out not to be fit for purpose, do you

5 agree that underlines the need for very early active

6 steps to look at availability of supplies of PPE?

7 **A.** It also goes to the point I was making earlier just

8 about contingency and levels, I agree. I agree with the

9 minister's comments, the way in which the virus then

10 progressed subsequently, despite the fact that we had

11 13 weeks of supply that was technically available in the

12 pandemic stock, that ran down much quicker than we were

13 expecting, but we were able to pursue both through UK

14 level arrangements and through our own local supply

15 chain a way of maintaining that national supply to be in

16 place.

17 **LADY HALLETT:** I think you need to go on to one of the next

18 two questions, Ms Harris, I'm afraid. That was a very

19 long introduction to your first question.

20 **MS HARRIS:** It was indeed, thank you.

21 **LADY HALLETT:** Most of it wasn't allowed.

22 **MS HARRIS:** Thank you.

23 I'd like to ask you about social care, and we know

24 that, and may I take Dr Goodall very briefly to the

25 document in relation to this, and I do appreciate that

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1 I think, really importantly, is that we were going to

2 ensure that we stepped into the difficulties of PPE

3 supply for social care, and we over time expanded that

4 very significantly. Out of 2 billion items that we

5 provided across Wales in the whole of the pandemic

6 response, about 800 million were provided to care homes,

7 so about a third of the overall response, and that felt

8 appropriate.

9 **Q.** But this was --

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

11 **MS HARRIS:** Thank you, my Lady.

12 **LADY HALLETT:** Sorry.

13 Ms Foubister.

14 **Questions from MS FOUBISTER**

15 **MS FOUBISTER:** Thank you, my Lady.

16 Good morning, Dr Goodall, I represent

17 John's Campaign and Care Rights UK.

18 I'd like to refer first to your statement of

19 29 September 2023, which is the one dealing with the

20 Health and Social Services Group.

21 That's INQ000319643.

22 When we get there, I'm going to go to your page 71,

23 paragraph 242.

24 You note here that you wrote to NHS bodies on

25 5 May 2020 identifying action that should be taken to

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1 I need to be quick.

2 It is a document at INQ000252549, if that could be

3 pulled up, please. Thank you.

4 This is a written statement by Mr Vaughan Gething,

5 "Distribution of ... (PPE) to social care settings", and

6 it's on 19 March, second paragraph:

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

8 PPE."

9 And at the fourth paragraph goes on to say:

10 "If PPE stock cannot be accessed ... [Document

11 read] ... if a case of Covid-19 has been confirmed."

12 Is it right that that was the first substantial help

13 that was given to social care in relation to PPE and up

14 until then they had been left largely to fend for

15 themselves?

16 **A.** I can't -- I can't really recall -- I can't recall the

17 run-up to this, but this was reflecting our advice and

18 actions and interventions. I know that on 9 March we

19 had introduced arrangements to make sure we were able to

20 put additional supplies into GPs right across Wales, and

21 we were working our way through how we would want to

22 respond.

23 Of course individual care homes would have had

24 a level of PPE supplies supported by their local

25 authorities at the time. What this was triggering,

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1 ensure cancer services provision, including to put in

2 place support systems to deal with concerns from cancer

3 patients regarding social isolation and shielding.

4 Why did you raise a concern specific to cancer

5 services?

6 **A.** At that time as we were tracking the virus -- I think

7 I'd also written out in April and some work had been

8 done by our cancer network in Wales -- we were concerned

9 that the data we were receiving was showing that with

10 the lockdown arrangements in place the numbers of cancer

11 patients accessing services had reduced. So that is

12 patient who are concerned about cancer rather than

13 diagnosed with cancer. And it was just very visible to

14 us in our very early data that we needed to do something

15 more about that. We wanted to make sure that essential

16 services were available for the NHS, even though we had

17 stood down some very individual services across Wales,

18 and cancer was one of those services, not uniquely so.

19 **Q.** I think some of that data you refer to is at the next

20 document I was going to turn to, which is INQ000300217.

21 This, when we get there, is an impact assessment

22 document from later on, from November 2020, and I'm

23 going to go to page 20, the first sentence, and also

24 there's a diagram which we should be able to see at the

25 bottom of the page.

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1 So are you aware, as it states here, that the number
 2 of cancer patients on the NHS wait list increased
 3 8.9-fold from the beginning of March to 12 June 2020?
 4 **A.** Yes, I did, I was tracking the data because it was
 5 an area of concern, yeah.
 6 **Q.** What was the response to your letter of 5 May, the one
 7 I referred you to a moment ago?
 8 **A.** We were overseeing these arrangements through our
 9 essential services group, that local organisations were
 10 looking to see how they could recover some of that
 11 activity. The Cancer Network in Wales was really
 12 helpful in giving support to local organisations but
 13 there was always a balance that, whatever the national
 14 framework that was in place, organisations needed to
 15 bring patients back in safely, so the operational
 16 delivery of that was very much with local health boards
 17 as organisations.
 18 **Q.** Were your concerns around this taken into account by
 19 decision-makers?
 20 **A.** I do think that they were taken into account because we
 21 were very clear that we needed to maintain a focus on
 22 accessing services. But these were numbers as that as
 23 your data was showing was a worry, because they were
 24 deteriorating. One of our worries were that people, if
 25 they weren't accessing the services now, we would end up

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1 quarterly we were describing these broader areas and the
 2 importance of making sure that whenever activity could
 3 be recovered that it should be done so.
 4 **MS FOUBISTER:** Thank you.
 5 Thank you, my Lady.
 6 **LADY HALLETT:** Thank you very much, Ms Foubister.
 7 I think that completes the questioning for
 8 Dr Goodall.
 9 **MR POOLE:** It does, my Lady, yes.
 10 **LADY HALLETT:** Thank you very much for your help so far,
 11 Dr Goodall. I'm sorry, I can't give you a guarantee
 12 that it won't be the last time. I know that you've
 13 helped me before in another module and this one, and it
 14 may be we'll call on you again, but thank you very much
 15 for your help.
 16 **THE WITNESS:** Okay, thank you very much. Diolch yn fawr
 17 iawn.

(The witness withdrew)

19 **LADY HALLETT:** Ms Jung.
 20 **MS JUNG:** My Lady, the next witness is Dr Tracey Cooper.
 21 **DR TRACEY COOPER (affirmed)**
 22 **Questions from COUNSEL TO THE INQUIRY**
 23 **LADY HALLETT:** I'm sorry if we've kept you waiting, I'm
 24 afraid we're not going to finish you before we have to
 25 break for lunch.

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1 with them coming later in their pathway experience and
 2 we just wanted to make sure we could intervene as soon
 3 as possible, despite how much of the virus was around
 4 and about us at the time.
 5 **Q.** So you refer to data on the cancer services, were you
 6 aware about serious concerns being raised about the
 7 adverse impact of isolation on people with other health
 8 conditions such as dementia or Alzheimer's?
 9 **A.** I was aware of that, I think the TAC report that you've
 10 pulled up actually reflects on that itself in respect of
 11 some of those broader impacts, not least on the
 12 shielding, irrespective of the impact of lockdowns as
 13 well.
 14 We obviously had to focus on those broader harms as
 15 we progressed more so through wave 2 into wave 3 of the
 16 pandemic response, and we did include reference to those
 17 areas within our quarterly operating frameworks that
 18 were issued from the NHS.
 19 **Q.** Did you write any equivalent letter to your May letter
 20 drawing attention to those concerns for these other
 21 health conditions and asking for specific action in
 22 relation to those?
 23 **A.** I didn't. There was something very specific about
 24 cancer that we saw on the data that we were monitoring.
 25 Within our operating frameworks that I was issuing

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

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1 A. That's correct.
 2 Q. Did you have input into that statement?
 3 A. I did, yes.
 4 Q. Are both of those statements for Module 1 true to the
 5 best of your knowledge and belief?
 6 A. They are.
 7 Q. Thank you.
 8 Moving on to your professional background and role,
 9 Dr Cooper, is it right that you are the chief executive
 10 of Public Health Wales and that you have been in that
 11 role since June 2014?
 12 A. That's correct.
 13 Q. You qualified with a bachelor of medicine from
 14 Southampton University in 1990?
 15 A. That's right.
 16 Q. Prior to your appointment as chief executive of Public
 17 Health Wales, you worked as the inaugural chief
 18 executive of the Health Information and Quality
 19 Authority in the Republic of Ireland between August 2006
 20 and May 2014?
 21 A. That's correct.
 22 Q. Before that, you were the deputy head director of
 23 operations for the NHS Clinical Governance Support Team,
 24 Modernisation Agency, Department of Health England
 25 between January 2004 and August 2006?

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1 A. That's correct, yeah.
 2 Q. It's also an NHS Trust?
 3 A. It is, yes.
 4 Q. And it's also a Category 1 responder for the purposes of
 5 the Civil Contingencies Act?
 6 A. It is.
 7 Q. And therefore plays a key role in relation to the
 8 preparation for and response to emergencies and major
 9 incidents, which includes pandemics?
 10 A. Yes.
 11 Q. Moving on to the role of Public Health Wales in response
 12 to the Covid-19 pandemic, please.
 13 In the corporate statement you say that Public
 14 Health Wales mounted an unprecedented response to the
 15 pandemic, which was part of a Welsh system-wide effort
 16 to respond effectively to the challenges faced as the
 17 pandemic progressed; is that right?
 18 A. That's right, yeah.
 19 Q. Could you please provide a brief summary of what Public
 20 Health Wales' role was in response to the pandemic,
 21 please.
 22 A. Of course. So early on in the pandemic when, which I'm
 23 sure we'll come on to, we could see what was coming down
 24 the line, we mobilised the organisation to the point
 25 that by 24 February we'd already made the decision that

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1 A. That's correct.
 2 Q. You also have experience of working internationally,
 3 including with the World Health Organisation?
 4 A. That's correct.
 5 Q. The International Association of National Public Health
 6 Institutes?
 7 A. Yep.
 8 Q. And the International Society for Quality in Health
 9 Care, of which you were a board member from 2008 to
 10 2015, and president between 2011 and 2013?
 11 A. I was, yes.
 12 Q. I want to ask you next about the role of Public Health
 13 Wales and a bit about its background.
 14 A. Yes, so Public Health Wales was established in 2009 and
 15 it was part of the health structural reforms in Wales at
 16 that time. It was established under a statutory
 17 instrument with four main statutory functions. And
 18 perhaps if I can summarise them, they are to deliver
 19 health protection, microbiology and screening services,
 20 to provide health improvement programmes, to undertake
 21 data analysis to survey the health of the population,
 22 and to undertake research and evaluation about the
 23 health of the people of Wales.
 24 Q. Thank you. And is it right that Public Health Wales is
 25 the national public health agency in Wales?

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1 Covid response was going to be a single priority of the
 2 organisation.
 3 So we mobilised the organisation and then we scaled
 4 up core functions and activities that were relevant to
 5 protecting the public, particularly around our
 6 microbiology diagnostic functions, our health protection
 7 functions, our population surveillance functions.
 8 We also provided a broad range of technical and
 9 professional expertise and advice to the Welsh
 10 Government, guidance to partners. We undertook tracking
 11 of the course of the virus, and its impact on the
 12 population, which changed and evolved through the
 13 various phases of the pandemic. And we also undertook
 14 research and evaluation not only in relation to the
 15 impact of the infectious nature of coronavirus but also
 16 the impact it had on the wider socioeconomic health
 17 harms.
 18 Q. Thank you.
 19 Can I ask you about some matters that weren't
 20 covered in that very helpful explanation. What was
 21 Public Health Wales' role in contact tracing?
 22 A. So, as is normal for public health practice for any
 23 public health body, contact tracing is a standard health
 24 protection response where there is a health --
 25 an infectious disease incident. And so that's normal,

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

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

15 And so, through the course of February and March,
16 our teams -- we just were pouring more and more staff
17 into the national contact tracing cell, tracing over
18 100 contacts that were coming in. And so that -- and at
19 the time we were the sole organisation doing that
20 contact tracing.

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

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

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

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

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

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

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

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

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

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

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

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

23 **Q.** Thank you.

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

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

11 Unfortunately neither ourselves or the Welsh
 12 Government knew about that. And so literally over the
 13 course of about four or five days the team developed
 14 standard operating procedures, worked through the
 15 process, the end-to-end process, and I think by 7 April
 16 we were up and running, delivering it. The reason being
 17 that it was there and of course we couldn't not use it,
 18 but it hadn't been planned. So we ran that for about
 19 60 days. The team did amazingly, actually, and we then
 20 handed that over safely to Cardiff University health
 21 board.

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

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

8 **MS JUNG:** Thank you.

9 My Lady, would that be a convenient time to break?

10 **LADY HALLETT:** Certainly.

11 Just one question. Did I hear you correctly that
 12 somebody decided to set up a mass population sampling
 13 centre in Cardiff without telling the Government of
 14 Wales or Public Health Wales?

15 **A.** Indeed, my Lady.

16 **LADY HALLETT:** Right.

17 **A.** It turned out --

18 **LADY HALLETT:** Do we know who that was?

19 **A.** -- to be helpful. I don't know.

20 **MS JUNG:** Was it Deloitte?

21 **A.** I think it was part of -- well, Deloitte had been asked
 22 to set it up. I think it was part of the intention to
 23 create that -- the mass sampling, obviously the swab,
 24 and the mass testing across the UK. I don't know who
 25 made the decision though.

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1 an area that we wouldn't have expected, ourselves, to
 2 do.

3 **Q.** Just to give us an idea of the strain on your resources,
 4 what was the capacity of staff working in the National
 5 Contact Centre and in that mass sampling centre?

6 **A.** Well, in the National Contact Centre we -- I think the
 7 peak we had at maximum was about 800 calls a day. And
 8 that waxed and waned through different phases of the
 9 pandemic and then we were able to transfer that into
 10 a different, much more reduced contact centre. But when
 11 we were establishing that, very literally overnight, we
 12 took over half of our -- fourth floor of an office. We
 13 then rolled it into Swansea and we rolled it into
 14 North Wales so that we could have some resilience. And
 15 our IT team ensured that, later on, we could -- people
 16 could be call handlers from -- working from home.

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

21 In relation to the sampling centre, it -- on
 22 18 March, unfortunately we had to make the decision to
 23 suspend our -- the majority of our national screening
 24 services, with the minister's approval, because of going
 25 into the delay phase and the impact that had, whilst we

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1 **MS JUNG:** Thank you.

2 **LADY HALLETT:** Extraordinary.

3 Right, I shall return at 1.45.

4 **(12.45 pm)**

(The short adjournment)

6 **(1.45 pm)**

7 **LADY HALLETT:** Ms Jung.

8 **MS JUNG:** Thank you, my Lady.

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

12 Can we start, please, by confirming that Public
 13 Health Wales did not take part in any informal or
 14 private communications such as WhatsApp groups with
 15 ministers or senior servants that informed significant
 16 decision-making --

17 **A.** No.

18 **Q.** -- and as such doesn't hold any records?

19 **A.** No.

20 **Q.** You say that in the context of Covid-19 the requests for
 21 advice from the government increased significantly.
 22 When did that increase happen, was it gradually over the
 23 whole time, or did it ramp up after a certain time?

24 **A.** I would say from around about middle of February, it
 25 started to, to increase. We were already providing

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

9 **Q.** Thank you.

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

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

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

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

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

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

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

16 **A.** Yes, it was a very crucial period.

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

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

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

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

16 **A.** Sorry. Sorry.

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

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

24 **A.** Not in a --

25 **Q.** -- in that initial period?

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

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

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

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

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

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

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

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

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

22 A. Absolutely.

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

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

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

5 Is that similar to what happened with Public Health
 6 Wales?

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

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

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

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

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

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

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1 where you did have direct meetings with ministers, but
 2 was that direct line always open throughout the
 3 pandemic?
 4 **A.** Well --
 5 **Q.** Can I work through an example?
 6 **A.** Yes, please do.
 7 **Q.** So Professor Nick Phin said that in Scotland there was
 8 a situation where the government had decided that they
 9 should be checking up on people to make sure that they
 10 were maintaining quarantine and that that led to
 11 a reasonably robust exchange between the chief executive
 12 of Public Health Scotland and the Scottish Government,
 13 where Public Health Scotland were saying it just wasn't
 14 a feasible option.

15 Am I right in understanding that something similar
 16 happened in Wales, where Dr Sandifer says that he
 17 received an email from the Welsh Government on
 18 31 May 2020 with an expectation that Public Health Wales
 19 would write to all overseas travellers by recorded
 20 delivery letter, followed by telephone contact for
 21 monitoring, and he had to write back pointing out the
 22 difficulties with that. First of all, Public Health
 23 Wales could not access the passenger locator form
 24 database held by the Home Office; and, secondly, did not
 25 have the operational requirements to be able to send out

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1 meetings?
 2 **A.** So these really took the nature of a quick half hour,
 3 what we were learning internationally, what were the
 4 concerns we had, where was Wales at. No decisions were
 5 made at those meetings, and they were very similar to
 6 what we'd have done pre-Covid in quite a relaxed
 7 catch-up way. And on occasion the Chief Medical Officer
 8 may ask us to provide advice to him on X, but they were
 9 not -- they weren't formal structured agenda -- we
 10 wouldn't share an agenda, it was very much a rapid
 11 situational -- sit rep, if you like.
 12 **Q.** Bearing in mind that Public Health Wales got its first
 13 briefing through Public Health England on 8 January, do
 14 you think that those meetings with the Chief Medical
 15 Officer should have started earlier?
 16 **A.** Well, my understanding, and again Quentin is closer to
 17 this than me, so in -- my understanding is that, and
 18 I think the first meeting with Public Health England was
 19 the 7th, we issued a briefing to the NHS on the 8th, and
 20 then again on the 10th.

21 But the team, under the auspices of Quentin, were
 22 already very close in communications with the first --
 23 with the Chief Medical Officer, so it wasn't that no
 24 engagement happened, it was the fact that we, from
 25 26 January, we start -- we just scheduled into the

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1 150 recorded delivery letters a day followed by daily
 2 phone calls, 14 days for each arrival.

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

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

17 **Q.** Thank you.

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

23 So you say that informal catch-up meetings happened
 24 with the Chief Medical Officer for Wales, starting from
 25 26 January 2020. What did you mean by informal catch-up

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

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

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

10 **A.** No.

11 **Q.** Do you think they should have been recorded?

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

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

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

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1 them, but yes, as far as I'm aware.

2 **Q.** Do you know what the purpose of those meetings were?

3 **A.** Yes, I think it was very much, we worked very closely,
4 as Category 1 responders, and Welsh Ambulance service
5 trust is a key responder, so when we're into an incident
6 we engage with them regularly, and at that time -- it
7 was at the beginning of that time Covid was deemed to be
8 a high-consequence infectious disease, and so the
9 transportation for the ambulance service of patients who
10 are, who have a -- potential or have a high-consequence
11 infectious disease is significant for them logistically.
12 So my understanding is those meetings were set up
13 originally to work through with them how they would go
14 about undertaking that transport, and then of course
15 subsequently it was de-designated as a high-consequence
16 infection, and so they fell away and the next phase of
17 the pandemic kicked in, if you like.

18 **Q.** Albeit Covid-19 was designated formally as
19 a high-consequence infectious disease, is it right that
20 from the very outset it was at least out of an abundance
21 of caution treated as if it was?

22 **A.** Yes.

23 **Q.** Bearing that in mind, do you think that the meetings
24 with the ambulance trust should have happened earlier,
25 to warn them about potential cases coming in?

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1 Do you agree with that?

2 **A.** Without an example -- it would be helpful if there was
3 an example. I -- and, I mean, having read that
4 paragraph, the beginning of the paragraph is in the
5 context of data, I think, that's right, data and
6 modelling --

7 **Q.** He goes on to say, if it assists, that during the
8 pandemic -- he says "We needed it to be more in the
9 delivery space, such as ramping up testing capacity, but
10 it struggled to be so effective". And then he goes on
11 to say that as ministers you only hear about what goes
12 wrong.

13 **A.** So if I could perhaps cover the first element, around
14 the -- the beginning of that paragraph --

15 **Q.** Yes.

16 **A.** -- around data, and then perhaps make a comment around
17 scaling up services, particularly testing.

18 So there were times early on, I would say, earlier
19 on, where there was such a rapidity of questions and
20 requests for data, understandably, from colleagues in
21 Welsh Government, from ministers -- and I mean multiple
22 times in an hour, through the day -- and we had put all
23 of our data analysts from across the organisation into
24 our Communicable Disease Surveillance Centre, and so to
25 keep up with those was a challenge.

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1 **A.** We were briefing the ambulance trust as with the rest of
2 the NHS, so when we sent the briefing out on the 8th and
3 the 10th, we sent it out to the NHS, and that's all of
4 the organisations.

5 So again, whilst the date of a meeting was X date,
6 there were multiple engagements happening with the
7 ambulance service. And I can remember personally on
8 a Sunday being in our offices in early February where we
9 had a potential case and being on a conference call,
10 because I was helping in the contact centre, because the
11 ambulance service were trying to work out the logistics
12 with the health board. So they were aware of it, of the
13 risks of Covid, at the same time as we were when we
14 briefed the NHS.

15 **Q.** And talking about the NHS, the Health and Social
16 Services Group coronavirus planning and response group
17 we dealt with that with Dr Goodall this morning, but
18 that group started on 20 February 2020. You've told us
19 that prior to that you were in contact with the NHS --

20 **A.** Yes.

21 **Q.** -- the ambulance trust; is that right?

22 The First Minister, Mark Drakeford, has said in his
23 statement that at times the relationship between the
24 Health and Social Services Group in Welsh Government and
25 Public Health Wales was difficult.

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1 Sometimes, on occasion, there were the same question
2 coming from different parts of the Health and Social
3 Services Group, and later in the pandemic we created
4 a group that could co-ordinate that better, and we tried
5 a number of times with that. And also there were times
6 where through the course of the pandemic we were asked
7 to add additional fields to the population surveillance
8 dashboard that we'd published, which expanded rapidly.
9 Sorry.

10 And I can remember an engagement with
11 Andrew Goodall, I think it was probably in the summer,
12 where we'd been asked to add a significant number of
13 additional fields, and it just logistically wasn't
14 possible in the time they asked for if we wanted to have
15 the quality of the data integrity. Because in order to
16 do it we had to test the source data. So we had to
17 negotiate on occasion.

18 So that's what I'm assuming. That's how I interpret
19 the First Minister's comments. I would say that there
20 was some frustrations from our side as well and every
21 few months we tried to create that -- a better control
22 system.

23 The meeting I referred to was, I think, from
24 September/October. A number of our team met weekly with
25 the Chief Statistician for health so that they could

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

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

6 **Q.** Yes.

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

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

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

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

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

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

13 **Q.** Thank you.

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

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

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

25 So --

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

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

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

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

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1 **Q.** On a mass scale?

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

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

15 **Q.** Thank you.

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

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

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1 boards -- oh, sorry.

2 **Q.** I've got meetings with health boards starting in

3 February, and then meetings with directors of public

4 health from March --

5 **A.** Yes, sorry. We had so many meetings, apologies.

6 I think you may be alluding to, in early February

7 I contacted my colleagues, health board chief

8 executives, suggesting that we did one-to-one

9 organisation-to-organisation calls with them. And, yes,

10 that was very much about -- and I think I shared the

11 agenda -- where they -- where we were at as a country,

12 where they felt they were in preparedness, had they done

13 the training for face masks, how advanced were they in

14 setting up their community swabbing.

15 So we did those very positively with all of the NHS

16 organisations and I think I shared with you the

17 capturing of the output of those as emails that I sent

18 on to the Chief Medical Officer.

19 Soon after that, we met regularly anyway, as chief

20 executives, with Welsh Government, so that rhythm went

21 in -- I think that started at end of February, and then,

22 as I mentioned earlier, the more rapid frequent

23 directors of public health meetings were put in place.

24 **Q.** Thank you.

25 I've got one more group I want to ask you about,

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1 was proposed to establish the Covid public health

2 strategic co-ordinating support group, and that was

3 agreed to, and that started around about 23/25 March.

4 **Q.** 23 March, the date of the first lockdown.

5 **A.** Yes.

6 **Q.** Do you think that, bearing in mind the important role

7 that local resilience fora and the local government

8 played in the response to the pandemic, that they should

9 have been involved at an earlier stage?

10 **A.** Yes, I'm not sure exactly when colleagues in Welsh

11 Government directly through their Civil Contingencies

12 Group engaged with them, so I -- it could be that it's

13 much earlier. I do think, though, we felt that it was

14 on occasion, you know, we were holding the hands of the

15 NHS and running forward at speed, and they were holding

16 back, they were holding the hands as well, that we were

17 in a position where we felt we could see what was highly

18 probable coming down the line, by just observing what

19 was happening internationally, and that it was going to

20 move to a whole-of-society situation.

21 And so, again, I can't comment on Welsh Government,

22 when Welsh Government connected through the local

23 resilience fora to engage with them. We, however, were

24 connecting regularly. So on 25 February I asked the

25 team if we could establish -- if we could run

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1 it's the public health strategic co-ordinating support

2 group.

3 Can you tell us what the purpose of that group was

4 and why it was established?

5 **A.** Yeah, so that -- this came out of learning from the

6 Ebola virus disease outbreak, and during -- that was

7 2014/2015, if I recall -- during that we were very

8 heavily involved in working with our partners across

9 Wales in anticipation, because it was a real threat at

10 that time, and the local resilience fora were also

11 engaged in anticipation of any potential case that came

12 in.

13 What we identified, and again Dr Sandifer may be

14 better to elaborate on this because he led on it, what

15 we found at the time was Public Health Wales attending

16 the four local resilience fora, having very similar

17 conversations with them, at a busy time, and also them

18 not hearing the feedback from their colleagues,

19 a similar public health strategic co-ordination group

20 was set up during that time.

21 And so very early on under Quentin's leadership was

22 the suggestion "I think we need to have -- to do

23 similarly". So I understand that Quentin and colleagues

24 connected with local resilience fora partners who we'd

25 worked very closely with throughout the years, and it

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1 an exercise for a potential lockdown, and I spoke to the

2 Chief Constable of South Wales Police the following day,

3 and so we brought all the local resilience fora together

4 for that exercise on 3 March to test that out. So they

5 were engaged with us, but I don't know when it was

6 formal from a Welsh Government route.

7 **Q.** Thank you.

8 You've alluded to it already, but you made a comment

9 just shortly before about there being so many groups.

10 Do you think that the routes through which advice was

11 provided to the Welsh Government could or should have

12 been simplified?

13 **A.** I think in the early months it was -- it was -- there

14 were -- as I said earlier, there were multiple contacts.

15 When systems started to be put in place, when TAG was

16 put in place, I think that really was the point at which

17 advice was much more helpfully streamlined, because

18 there was a system in place, there were designated

19 groups that -- subgroups that evolved over time, because

20 the advice was about everything. And so it's -- I think

21 it's that, it's that divergent activity. And then

22 structure gets put in place which creates organisation

23 within a very challenged environment.

24 So the point -- from my perspective, I think the

25 point that TAG was established made it earlier. I'm not

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

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

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

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

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

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

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

9 And then finally, just as examples, in the April of
 10 2020 as an organisation we wanted to travel alongside
 11 the public on this, so we began a weekly public
 12 engagement survey, which was "How are we doing in
 13 Wales?" with 600 to 700 people, and we asked our -- the
 14 population some continuous questions around health and
 15 wellbeing, their self-reported state, and also questions
 16 in advance of vaccinations or restrictions. And that
 17 information was published, we published it -- published
 18 that all the time, but it also enabled Welsh Government
 19 to track that in informing.

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

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

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

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

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

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

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

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

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

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

15 **A.** Of course.

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

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

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

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

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

21 **A.** I would agree, yes.

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

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

3 Do you have any comments on that?

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

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

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

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

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

18 **Q.** Which we're going to cover.

19 **A.** Okay.

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

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1 **A.** I think in the first few months for us it was a real
 2 challenge, not because of the -- so much the platforms,
 3 because we had diversified them, but the biggest
 4 challenge was getting access to the chemicals. That was
 5 significant. What I would say is in March we procured
 6 additional platforms and then in August we put
 7 a business case in for 164 additional staff --
 8 **Q.** Yes.
 9 **A.** -- which were approved, and, you'll see in the
 10 statement, more equipment, but --
 11 **Q.** So we'll address those improvements that were made
 12 during the pandemic, but just sticking to the situation
 13 as at January 2020, the funding had come in from the
 14 government, can you tell us what improvements had
 15 actually been made at that stage in terms of the
 16 infrastructure or workforce?
 17 **A.** Prior to January 2020?
 18 **Q.** At the time that the pandemic struck.
 19 **A.** Okay, sorry. So we had procured additional pieces of
 20 equipment to be based in local hospitals, which means
 21 that results could be done rapidly locally without
 22 having to be transplanted to another part of Wales to be
 23 tested.
 24 **Q.** In how many hospitals?
 25 **A.** I think we had nine. I will go away and confirm, if
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1 **A.** Yes.
 2 **Q.** So there was no testing capacity within Wales in --
 3 **A.** For a --
 4 **Q.** -- relation to HCIDs?
 5 In your corporate statement, you say, Dr Cooper,
 6 that in exercising its role and functions, Public Health
 7 Wales was not held back in any way by the funding made
 8 available by the Welsh Government. There are no
 9 examples of insufficient funding curtailing the ability
 10 to fulfil Public Health Wales' role and functions in
 11 a timely manner in relation to the pandemic.
 12 Do you stand by that?
 13 **A.** I do. Sometimes on the business cases it took a little
 14 bit longer than we'd have liked for them to be approved,
 15 but -- and on one occasion it was less staff that we
 16 were -- that we'd asked for, but nevertheless it was
 17 a significant increase.
 18 So, yes, I don't have an issue with -- every time we
 19 put a business case in, most of the time it was very
 20 rapidly approved and -- so we were fortunate, actually,
 21 in that respect.
 22 **Q.** So I do want to explore some examples with you.
 23 It is the case, isn't it, that when Public Health
 24 Wales set out a business case for additional funding, it
 25 was granted --
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1 that's okay. I think we had nine what we call "hot
 2 labs", which are rapid diagnostics.
 3 **Q.** So you had nine hot labs already in January?
 4 **A.** Yes, I will check on the number but I'm pretty sure it
 5 was nine. And that allowed for rapid diagnostics.
 6 We also had some additional communicable disease
 7 surveillance teams that were starting to be appointed.
 8 I think we made -- we'd appointed a couple of additional
 9 consultants.
 10 We -- I'm not sure if we'd managed to appoint any
 11 additional Health Protection Team, because it was -- by
 12 the time it was approved in say September 2019, to
 13 mobilise and recruit all of those -- obviously it was --
 14 we went straight into the pandemic. But nevertheless
 15 the diagnostic infrastructure was better but it still
 16 would not have been enough at all to scale up to the
 17 level that we needed it to.
 18 **Q.** Just to clarify, with regard to high-consequence
 19 infectious diseases, is it right that they had to be
 20 tested in specific labs?
 21 **A.** Yes.
 22 **Q.** I think level 3 labs?
 23 **A.** Yes.
 24 **Q.** And is it right that in January 2020 that testing was
 25 still being done in England?
 158

1 **A.** Yes.
 2 **Q.** -- by the government?
 3 But in terms of timing, on 24 March 2020 you
 4 submitted a request for capital funding for Covid-19
 5 testing platforms to be placed at all microbiology
 6 laboratories in Wales, and that was to increase testing
 7 capacity --
 8 **A.** Yes.
 9 **Q.** -- is that right? And that was granted fairly quickly
 10 the next day on 25 March 2020.
 11 Is there a reason why that wasn't applied for prior
 12 to 24 March?
 13 **A.** Well, my understanding is -- and again -- that the 2019,
 14 I may need to come back and give you clarity around the
 15 specifics of it, but we had purchased additional
 16 platforms during 2019, but our team was --
 17 **Q.** This is in relation to Covid-19 --
 18 **A.** Yes.
 19 **Q.** -- testing platforms?
 20 **A.** Yeah. So the platforms to test Covid-19 are -- they're
 21 not unique for Covid-19, so they could test a number of
 22 respiratory viruses or other viruses, so you can
 23 have a -- one piece of equipment that can test a number.
 24 So we had to -- it was about making sure we could expand
 25 those that could test for Covid-19.
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1 So -- but we could see what was coming down the
 2 line, so similarly we knew we had to scale up our
 3 platforms, our staff, our chemicals, and that was -- and
 4 in March particularly, trying to increase our testing
 5 capacity, competing with the global supply chain, was
 6 a challenge. And on occasion, whilst we had the
 7 approval to purchase them, we struggled to get some
 8 equipment from South Korea, and we were in negotiations
 9 with Scotland to try and have a charter flight come
 10 down. So even though they were approved they were still
 11 a challenge to get into the country.

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

17 **A.** I don't know.

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

21 **A.** Yes.

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

25 **A.** Yes, so the swab test that people are familiar with is,
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1 particularly in those early months, while we knew it was
 2 coming down the line, we were still -- we were still
 3 unclear about what the scale was going to be and how
 4 long it was going to be for. And putting a business
 5 case in really early, when we've only got maybe ten
 6 cases, is a challenge to seek approval. When the
 7 business cases went in in March, it was much clearer
 8 that we were -- obviously the pandemic had been
 9 declared, and so it was a much more logical sequence of
 10 approvals. For the May, though -- as I say, the
 11 business case went in May because we weren't sure
 12 whether we'd be able to avail of the Lighthouse lab
 13 capacity at that time, which meant that we really needed
 14 to scale up to another level in Wales.

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

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

21 **A.** Yes.

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

25 It was known, wasn't it, that there was a lack of
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1 are -- which is something called the antigen, which is
 2 that someone has Covid at that time. What --
 3 serological is blood tests, and what that blood tests do
 4 is it measures whether someone has had Covid within,
 5 you know, the last number of months or so.

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

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

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

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

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

21 **Q.** That was later in August?

22 **A.** That's right, yes.

23 **Q.** But the application for funding was in May.

24 **A.** Yes, I think that is absolutely fair questions. I think
 25 from -- as we were travelling through the pandemic, and
 162

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

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

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

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

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

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

12 **A.** Yes.

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

15 **A.** Yes.

16 **Q.** -- staff.

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

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

23 **A.** Yes.

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

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

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

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

22 **A.** I'm really relieved to be able to say I -- we're in
23 a much better position, and we were actually able to get
24 122 additional staff into our health protection, the
25 others were vaccination leads. So we're -- I mean, 300

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

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

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

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

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

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

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

4 **Q.** Thank you.

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

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

14 **A.** That's correct.

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

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

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

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

25 Can you help us as to what kinds of incidents may

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1 require co-ordination and resources above those provided
 2 by normal operational capacity?
 3 **A.** Yes, of course. So where we are requiring additional
 4 resources into the response to an incident, where we
 5 have significant business continuity elements across the
 6 organisation such that other parts need to be mobilised
 7 in, and where we are being asked such a volume of demand
 8 from partners, that actually we need to move into
 9 another level of organisation around that.
 10 **Q.** Sorry to interrupt, but can you give us examples of the
 11 types of incidents where that sort of level of response
 12 might be appropriate?

13 **A.** So, for example, if we -- during the Ebola virus
 14 disease. Now, we fortunately didn't have a case in
 15 Wales but we had a highly probable case in Wales, and we
 16 reacted by obviously setting up our incident management
 17 team and were ready and prepared that if that had been
 18 a case, we would have gone into an enhanced level of
 19 response, which includes setting up a gold command.
 20 When we were responding to NATO -- so in 2014 NATO
 21 came to Newport, and in 2017 we had the UEFA Champions
 22 League cup final. So in -- during NATO we had our gold
 23 equivalent running. We had our silver equivalent
 24 running in the preparation and planning for NATO.
 25 **Q.** And we can see that a major incident, the scale of the
 169

1 information coming through and adapts accordingly, and
 2 it identifies actions that the organisation needs to
 3 take.

4 The silver group takes that direction from gold and
 5 enacts those actions, in essence, so mobilising the
 6 organisation, setting up cells or whatever that's
 7 needed.

8 **Q.** Thank you.

9 Can we go to the previous page, please.

10 We can see there the escalation from a bronze group
 11 up to a silver group up to a gold group within Public
 12 Health Wales. To the right-hand side we can see that
 13 a strategic co-ordinating group might feed in. Is that
 14 a multi-agency --

15 **A.** Yes, we feed into it.

16 **Q.** I think the arrows go both ways.

17 **A.** I know, it's probably --

18 **Q.** But is that normally led by the police?

19 **A.** It is traditionally, yes, it's part of the civil
 20 contingencies mechanism.

21 **Q.** And the tactical co-ordinating group?

22 **A.** Similarly. So in the same way, if there was
 23 a multi-agency incident, like a factory fire, our
 24 strategic director would attend the strategic
 25 co-ordination group and our tactical or incident
 171

1 incident response required for that is a more
 2 significant mobilisation of resources and a level of
 3 strategic response --

4 **A.** Yes.

5 **Q.** -- is that right?

6 Can we look at page 19, please. We can see there
 7 that when the enhanced response is activated, that would
 8 require notifying the executive, appointing a tactical
 9 incident manager, and establishing a silver group.

10 Would that normally be done at the same time as
 11 activating the enhanced level response?

12 **A.** Yes.

13 **Q.** And then for a major incident, you'd appoint a strategic
 14 director as well as a tactical incident manager, and you
 15 would establish a silver group and a gold group if
 16 needed.

17 **A.** And if I could say, under "enhanced", that's --
 18 obviously that's also an option of -- under our enhanced
 19 level, is appointing a strategic director in gold group.

20 **Q.** Just briefly, could you please explain to us the
 21 difference between a gold group and a silver group?

22 **A.** Of course. So our gold group is the strategic
 23 leadership group of the organisation in responding to
 24 an incident, so it sets the objectives, it sets the
 25 overall arching(sic) response plan, it considers
 170

1 director would attend the tactical co-ordinating group
 2 as part of local resilience forum mechanism.

3 **Q.** And what's the Emergency Coordination Centre (Wales)?

4 **A.** So that is the Welsh Government's units centre that
 5 it's -- that it chooses as part of the civil
 6 contingencies approach as to whether -- when and whether
 7 or not it establishes it. Its primary function is to
 8 assimilate data from partners across the country, to
 9 present that for government, for ministers, but also to
 10 be a centre of information to support ministers
 11 attending COBR. So it's -- if you like, it's
 12 an intelligence cell that provides some co-ordination of
 13 situational awareness.

14 **Q.** So is it the government's way of nationally
 15 co-ordinating a multi-agency --

16 **A.** Yes.

17 **Q.** -- response to a major incident?

18 **A.** Yes. And on occasion the ECC(W) may establish
 19 a strategic, national strategic co-ordination group
 20 itself. So if there was a national power outage,
 21 for example, we'd expect a national SCG running out of
 22 ECC(W), and so the respective levels would participate
 23 in that and would feed information down and feed
 24 information back.

25 **Q.** Does Public Health Wales have any say in whether that
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1 particular group is set up by the government or not?

2 **A.** No, I mean, we -- the decision is that of ministers to
3 establish, if -- I think if I'm correct in saying, and
4 that goes through their civil contingencies process.

5 I think I'm correct in saying that a Category 1
6 responder can suggest or propose or feed in suggestions
7 around ECC(W) being set up, but the actual decision to
8 establish it is that for government.

9 **Q.** So the enhanced level response internally within Public
10 Health Wales was set up on 22 January, but it's right,
11 isn't it, that the silver group wasn't set up until
12 28 January? Is there a reason why it wasn't set up on
13 the same day?

14 **A.** No, I think it was probably more about ascertaining the
15 information and understanding what was happening. What
16 was unusual for us, though, and it's worth pointing out,
17 is that Quentin and I had the discussion and Quentin
18 became strategic director on the 22nd, and we had our
19 first incident management team --

20 **Q.** I think it may have been the 28th -- forgive me for
21 interrupting. I think he was appointed the lead
22 strategic director on 28 January.

23 **A.** No, he was -- yeah, sorry, so he was appointed strategic
24 director on 22 January. What happened at the following
25 week is that we added two other members of the executive

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1 meeting with the Chief Medical Officer on a Monday,
2 following a meeting that I'd had with our incident
3 director on the Sunday just to say: okay, let's just
4 take stock here, where are we at in Wales? What's
5 happening across the world?

6 We were still yet to have the first case in Wales,
7 which wasn't until, as you know, the 27th, and it was
8 announced on the 28th, and out of that meeting we said:
9 actually, now is the time for us to set up a --
10 establish a gold group. Which met on the 25th.

11 That didn't -- that preceding time Quentin, as
12 strategic director, was still directing the response, so
13 I don't think that there was any disadvantage in us not
14 having that until the 25th. I think it was really more
15 about the timing of escalation of the response.

16 **Q.** Is it right that on 27 February you attended the Welsh
17 Government health and social care leadership meeting?

18 **A.** Yes.

19 **Q.** Am I right in understanding that that didn't have
20 anything to do with the Covid-19 response?

21 **A.** That's a Welsh Government meeting, and obviously Welsh
22 Government sets the agenda for that meeting.

23 **Q.** So it wasn't to do with Covid-19?

24 **A.** Well, the agenda was -- the -- Covid-19 wasn't on the
25 agenda to begin with. It subsequently became so because

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1 team so to give some resilience to strategic directors.

2 And just -- just for formality, Quentin became the lead
3 strategic director, but he was -- he was designated as
4 strategic director on the 22nd.

5 And then we had the incident management team for the
6 incident on the 23rd, which then helped influence what
7 the resources would be required for silver to mobilise
8 on the 28th. So there wasn't a delay, it was just the
9 running of the order.

10 **Q.** So you've told us that a gold group sets the strategic
11 leadership and objectives in relation to a major
12 incident. Why was the gold group not set up until
13 25 March?

14 **A.** So --

15 **Q.** Sorry, 25 February.

16 **A.** Yeah. So bearing in mind we'd set up our incident
17 management team and the silver group before we had had
18 any cases in Wales, so we were on a daily incident
19 management teams with the rest of the UK, we were
20 obviously seeing -- trying to help support, mobilise the
21 NHS, and more and more information was coming to light,
22 because it was still really -- whilst it was very busy,
23 it was still very, very early in understanding
24 coronavirus and the transmission.

25 And then on 24 February we had a strategic stocktake

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1 the Chief Medical Officer and I did a session.

2 **Q.** Well, I was going to ask you about your informal meeting
3 during the lunch hour with the director general for
4 Health and Social Services on that day.

5 You say you shared your concerns with him on that
6 day about the need to scale up services and the
7 importance of preparing and co-ordinating the NHS in
8 Wales for what was to come. First of all, is it right
9 that no minutes were taken of that --

10 **A.** No, it was literally over, grabbing food over lunch.

11 **Q.** Did he appear to you to understand the seriousness and
12 the urgency of what you were explaining to him?

13 **A.** Well, what we shared was pretty sobering. I know that
14 the Chief Medical Officer had been engaging with the
15 director general before that, as had I, with email
16 exchanges. So I'm assuming that the Chief Medical
17 Officer, as Dr Goodall said this morning, would have
18 been keeping him appraised.

19 We were significantly concerned at that point, and
20 during the meeting we went through where we think --
21 where we thought the NHS needed to be, and then in the
22 afternoon, you'll see in the agenda, I was talking about
23 something really not important in the context of Covid
24 and so we changed -- the Chief Medical Officer and
25 I changed that early afternoon and he and I presented to

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

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

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

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

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

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

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

5 **MS JUNG:** Thank you.

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

8 **LADY HALLETT:** Yes, certainly.

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

11 **LADY HALLETT:** Very well.

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

14 **THE WITNESS:** That's all right.

15 **LADY HALLETT:** -- your evidence today.

16 I shall return -- perfect timing, Ms Jung -- at
17 3.15.

18 **(3.00 pm)**

(A short break)

20 **(3.15 pm)**

21 **MS JUNG:** Thank you, my Lady.

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

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

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

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

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

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

3 **A.** Yes.

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

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

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

18 **LADY HALLETT:** By ministers?

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

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

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

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

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

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

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

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

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

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

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

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

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

13 At paragraph 98 you say:

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

22 Do you stand by that?

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

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

10 **Q.** Thank you.

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

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

20 **LADY HALLETT:** 2020.

21 **MS JUNG:** 2020, thank you, my Lady.

22 Why did you commission this exercise?

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

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

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

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

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

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

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

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

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

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

25 Certainly the signals at that time were that this --

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

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

12 **A.** I don't know.

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

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

25 As far as the specifics of PPE is concerned, our

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

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

13 **Q.** Thank you.

14 **A.** -- than the 23rd.

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

17 **A.** Yes.

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

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

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

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

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

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

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

23 My personal view, which is a non-technical view, is
24 it's difficult, isn't it, when -- we hadn't moved into
25 the lockdown. So actually at that point, unless you've
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1 them, because, to be honest, we were just so busy
2 ourselves. Well, we were asked around the Newport v
3 Treviso, as you've outlined, and we gave -- we proffered
4 advice around the Scotland/Wales because it was
5 fortuitous with the minister in the office. But I ...
6 yeah, I mean, perhaps it would have been helpful. I'm
7 not sure whether it would have changed the decision, to
8 be honest.

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

16 **Q.** Can I ask you about the Public Health Protection
17 Response Plan that you were asked to develop by the
18 government, by the Chief Medical Officer, on
19 22 April 2020.

20 The plan recognised, didn't it, that Wales had had
21 to respond rapidly to the pandemic, and that it had had
22 an unprecedented impact on society as a whole, including
23 that many people had died? It said now was the time to
24 prepare for the next phase of the pandemic, was it an
25 opportunity to pause and reflect and learn from past
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1 had a case or you were symptomatic, the public
2 weren't -- or if you were in a high-risk environment,
3 whether it's hospital or care home environment, where
4 you were really feeling it, the general public were or
5 weren't experiencing -- when we went into the lockdown,
6 it took it to another level.

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

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

23 **A.** No.

24 **Q.** Do you think it should have been?

25 **A.** We weren't going out seeking to be asked to advise on
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1 experiences.

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

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

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

24 So when we did the health protection response plan,
25 it -- we intended to cover the totality of the
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1 population's health, not solely the response to the
2 pandemic, the infection element of the pandemic, but
3 of course everything's connected to everything.

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

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

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

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

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

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

20 Do you agree with that?

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

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1 published?

2 **A.** By us or --

3 **Q.** Yes, by Public Health --

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

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

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

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

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

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

18 **A.** Yes.

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

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

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

5 So it didn't mean that we weren't looking at it,
6 I think it was -- it was a challenge in what data was
7 available as well for us to monitor it, and October --
8 of course before, prior to October, as we discussed
9 earlier, it was a more dispersed process for us in
10 producing advice. So in that October, particularly the
11 24 October advice note, that allowed us to really
12 central on, you know, short succinct "These are the
13 important things that need to be focused on", and from
14 that point onwards, really from 12 October, they became
15 very prominent.

16 **Q.** Thank you.

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

19 **A.** Yes.

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

21 Can we have a look, please, at INQ000336344. If we
22 look at page 2 of that document, we can see that there
23 is an email, initially, to you stating that there has
24 been contact from a number of care home operators and
25 managers expressing concerns that new residents are not
197

1 wrong?

2 **A.** Yeah, it's -- taking it into, I guess, the context at
3 the time, this was before Welsh Government had made
4 decisions around testing in relation to care homes, so
5 there was no policy decision on testing at that point.
6 The reference around testing was that at that point the
7 case definition didn't include residents in care homes,
8 if you recall, other than people who were symptomatic,
9 and so what was -- if someone had a fever or
10 a continuous cough, that was the indication for tests.
11 So the testing world was in a different space, and the
12 other element that was a challenge was that if someone
13 had a negative test, it didn't mean that they weren't
14 incubating Covid.

15 So at this point in time, it was -- the move -- the
16 world changed significantly as we went through April and
17 into May, and we were -- we had about a thousand tests
18 a day, so it was a really challenging time around
19 testing.

20 **Q.** I'm going to ask for one more document to be displayed,
21 please.

22 It's INQ000191663.

23 If we look at the -- we can see that this is a PHE
24 care home discussion paper dated 18 April 2020, and the
25 third paragraph, can we see there that it says:

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1 required to be tested for Covid-19 prior to admission,
2 and it says:

3 "As you are aware, residents in care homes are
4 amongst the most vulnerable ... [Document read] ...
5 could constitute a significant risk.

6 "... I would be most grateful if you could advise as
7 to whether ... [Document read] ... why this will not be
8 the case."

9 If we then look at the response from you above that,
10 you say:

11 "We recognise the challenge for residential
12 care home operators ... [Document read] ... personal
13 protective equipment by staff."

14 You go on to say that:

15 "New residents, should similarly be assessed for
16 signs or ... [Document read] ... test new residents
17 prior to admission."

18 Now, we know that later Public Health Wales issued
19 guidance which was consistent with that, and then later
20 still the government changed the policy, so that
21 everyone coming out of the hospital was being tested --

22 **A.** Yes.

23 **Q.** -- in light of the evidence of asymptomatic
24 transmission.

25 Do you now accept that your original advice was
198

1 "PHE arranged swabbing of all residents and staff in
2 6 care homes.

3 "Results from three ... [Document read] ...
4 negatives also symptomatic."

5 Then below that it says:

6 "So symptoms poorly predictive of infection
7 (therefore a poor trigger for control measures)."

8 Did Public Health Wales do any kind of investigation
9 like this by going into care homes and seeing for itself
10 what the rate of positive cases were in symptomatic and
11 asymptomatic cases?

12 **A.** We did further, I think about three or four weeks after
13 this, we did, we looked at a series of care homes that
14 hadn't had outbreaks and we looked at -- when we had
15 more testing capacity or all system testing -- all
16 care home testing.

17 What I would say in relation to this, though, is on
18 18 April we were -- had been routinely testing
19 symptomatic residents in care homes, since we had the
20 tests available, and on 6 April we started testing
21 symptomatic care home workers as part of the critical
22 workers policy, so -- because another element of this is
23 about the concern around the spread by staff. So
24 everybody was learning as this was materialising, and
25 this was at the time as well when we were working with
200

1 Welsh Government to amend the testing policy based on
2 Public Health England's document on 15 April, which was
3 the adult social care plan in which all residents on
4 discharge would be tested.

5 So on the 22nd, the policy changed here and I think
6 a letter came out from the Chief Medical Officer and the
7 deputy director general responsible for social care
8 outlining that everyone being discharged would be tested
9 and that there will also be a more prompt response into
10 clusters or incidents in care homes.

11 So this was quite a critical time that also helped
12 change the Welsh Government testing policy.

13 **Q.** Given that this was such an important group by size,
14 vulnerability and the severity of adverse impact, do you
15 think that that kind of investigation ought to have been
16 done before you were advising that asymptomatic people
17 did not need to be tested?

18 **A.** Well, our -- the advice around asymptomatic -- the
19 testing of asymptomatic people was advice that was being
20 worked through not only by us but also, as with this,
21 the UK-wide incident management team, and the world was
22 evolving around evidence of -- there's a difference
23 between asymptomatic transmission and someone who has it
24 who is asymptomatic, as you know. So we were learning
25 together on this, and the PHE 6 study, which is what it

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1 Can you explain what you meant by --

2 **A.** Yes, I think it was a challenge because regardless of
3 the policy strapline or, you know, the public
4 communication, you've also got the media. So in the
5 first few months the UK media tended to default to the
6 decisions that were being made by the UK Government
7 vis-à-vis England. That did improve, and as the months
8 went by they would differentiate, that in -- this is
9 what's happening in Wales, this is what happens in
10 Scotland, Northern Ireland, England, but in the first
11 few months it became really confusing for people.

12 I think when we -- when Wales, when all of the
13 countries started to diverge, particularly coming out of
14 that first lockdown, I think there were a number of
15 occasions where a strapline of a policy created quite
16 a lot of problems in other countries that were still
17 being a bit more cautious. I don't think there's any
18 easy answer to solve that.

19 I think the early engagement with the media is
20 really key because people will tend to default perhaps
21 to the UK rather than the national -- so whether there
22 is an opportunity to work more closely with the media at
23 the outset, possibly.

24 The other elements really was about ensuring --
25 which we worked closely with the Welsh Government on --

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1 became known as, it -- just because that was England,
2 didn't mean that we were all learning from that.

3 So later on in the pandemic, we all did quite a lot
4 of different studies within the countries, but this was
5 just as important to us regardless of which country it
6 had been done, we didn't necessarily need to fast-track
7 one in Wales to not take this on board, and our
8 challenge was testing capacity.

9 By the time we got -- at this point we had -- we'd
10 increased to a couple of thousand, and then in May we
11 were really able to expedite all of testing. So I think
12 on 2 May we did all testing of symptomatic and
13 asymptomatic staff and residents in care homes with
14 a new outbreak. And then two weeks later the same in
15 care homes without an outbreak, because we were
16 concerned -- which is back to your question -- we were
17 concerned about what was happening in places that hadn't
18 logged an outbreak that potentially could have
19 transmission that wasn't being picked up.

20 **Q.** Thank you.

21 In relation to public health communications, you say
22 in your personal statement that in your view an area
23 that could have been better was in relation to clearer
24 public messaging when there was a clear divergence in
25 restrictions compared to other UK nations.

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1 after a few months, was the behavioural insights
2 messaging. So if you're going to change your message,
3 you have to perhaps tailor it more to the view of the
4 mood music of the population, and then also further
5 tailor it to different population groups.

6 So I think there is learning in there for us.

7 **Q.** Thank you.

8 And finally, on reflection, is there any other
9 learning that you would like to highlight? Is there
10 anything that you think Public Health Wales could have
11 done better?

12 **A.** Oh, I'm sure there's lots and lots of things that we
13 could have done better. I think the key -- three key
14 learning points really. I mentioned -- one I mentioned
15 earlier was just get the battle rhythm up and running.

16 The second I would say is about respective roles and
17 responsibilities, because I think they were muddy for
18 the first few months, and having us all lived through
19 this, I think that has improved. There was a health
20 protection review undertaken that the Chief Medical
21 Officer commissioned that was helpful to that. So
22 I think that's the second one.

23 And I think the third one is, you know, very much
24 about the welfare of staff. So for us we spend a lot of
25 time around the welfare and well-being of our staff, and

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1 trying to do as much as we can on that. Because,
2 you know, people expect an incident to have a beginning,
3 a middle and an end; this just kept going. And so the
4 sustainability, be it a care home, be it a hospital, be
5 it an organisation like us, yeah, I'm not sure enough
6 has been done to say: okay, well, how do we really,
7 really try and address that? We've got more staff now,
8 which is great, but that's not the same as everywhere.

9 So I think that's a -- that's a continued challenge
10 that I think something needs to be factored into what we
11 can do for learning.

12 **MS JUNG:** Thank you.

13 My Lady, those are all my questions. I believe
14 there are some --

15 **LADY HALLETT:** Thank you very much.

16 **MS JUNG:** -- questions from core participants.

17 **LADY HALLETT:** There are.

18 Ms Shepherd.

19 **Questions from MS SHEPHERD**

20 **MS SHEPHERD:** Good afternoon, Dr Cooper. I appear on behalf
21 of Covid-19 Bereaved Families for Justice Cymru, and my
22 question focuses on ventilating indoor spaces and in
23 particular public communications regarding ventilation.

24 I don't propose to bring it up on the screen, but in
25 your corporate witness statement you set out some of the
205

1 **Q.** There we are. We can see in column E, and it's in bold
2 actually, it sets out that SAGE endorsed the EMG paper
3 on airborne transmission. So EMG, the Environmental
4 Modelling Group, a subgroup of SAGE. In column F, we
5 can see that it's a document that was entitled "Role of
6 aerosol transmission in Covid-19", and this was endorsed
7 by SAGE on 23 July.

8 At this point, Public Health Wales had access to
9 SAGE advice papers; is that right?

10 **A.** Yes.

11 **Q.** What's said is that:

12 "SAGE noted its findings ... [Document read] ...
13 good ventilation."

14 So if Public Health Wales didn't get involved in
15 a public messaging campaign about ventilation, are you
16 able to say why not?

17 **A.** Well, we were -- we were involved closely in all of the
18 advice around ventilation, but particularly in places
19 like schools, and in fact we spent a lot of time
20 providing support. The campaign -- it's maybe worth
21 just saying that the campaigns originated in two ways.

22 So a lot of the strapline campaigns, as I would call
23 them, were Welsh Government. We didn't design them. We
24 further -- we disseminated them but they weren't -- they
25 weren't our campaigns. We did lead on the campaign to
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1 public messaging campaigns that Public Health Wales has
2 a role in delivering. These include the wash-your-hands
3 message, the stay-at-home message, and an advertising
4 campaign to encourage pregnant women to get the vaccine.

5 What's not on the list is a campaign regarding the
6 importance of ventilation.

7 Firstly, was Public Health Wales involved in
8 a public messaging campaign about the importance of
9 ventilation as a mitigation against the spread of
10 Covid-19?

11 **A.** I don't -- I can't recall if we were. Dr Sandifer's
12 giving evidence tomorrow, so it would be worth asking
13 him. So we may have done, I'm not familiar with it, and
14 we didn't put it in the statement, so that may have been
15 no.

16 **Q.** I just want to provide some context. There's
17 a document, INQ000220539. Just for context, this is
18 a paper from the Welsh Government, and it just sets out
19 all of the advices that SAGE provided in July of 2020.

20 At row 39 of that document -- I'll just wait for it
21 to come up. So I don't know whether it's possible to
22 get row 39 up, I appreciate it's an Excel spreadsheet so
23 it's a bit different. We can see in column -- I'll wait
24 for that to come up.

25 **A.** Yeah.

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1 encourage pregnant ladies to get vaccinated, but I think
2 it's a fair -- it's a fair question.

3 So I guess my answer is: just because we weren't in
4 -- didn't do a campaign, doesn't mean we weren't
5 involved in it. But I think it's a fair challenge back
6 to say: well, did we think to do one? I wasn't involved
7 in all of our technical conversations, so Quentin may be
8 able to enlighten further. But I think it's a fair
9 question, actually, and maybe that's something that we
10 need to reflect on.

11 **Q.** If I could ask one follow-up question: is the reason why
12 it's a fair question perhaps because, as understanding
13 about airborne transmission evolved, the focus perhaps
14 needed to move away from washing hands towards
15 ventilation? Is that reasonable?

16 **A.** I think it would be both. I think the hand hygiene was
17 always and will always be a prominent aspect of
18 infection prevention and control. Yeah, I think from
19 the ventilation element there was a lot of guidance on
20 it, and of course it was different in different
21 environments. So whilst you can put, you know, clear
22 principles, the actual public health advice would be
23 different depending on the environments. But I think
24 that's -- it's a fair question, and so I would say it's
25 both and -- and I'll take it back to the ranch as well
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1 and have the conversation about, you know, is that
2 something that we should think about doing, should we be
3 in this situation again.

4 **MS SHEPHERD:** Thank you very much, Dr Cooper.
5 Thank you, my Lady.

6 **LADY HALLETT:** Thank you, Ms Shepherd.
7 Ms Foubister.

8 Questions from MS FOUBISTER

9 **MS FOUBISTER:** Thank you, my Lady.

10 Good afternoon, Dr Cooper, I represent
11 John's Campaign and Care Rights UK.

12 You've explained this afternoon and in your
13 statement about the role of Public Health Wales,
14 including to provide advice on the indirect harms of the
15 pandemic on population health and well-being, and that
16 your advice recognised decisions needing to balance
17 considerations which included the wider harms of
18 interventions.

19 If I could bring up INQ000251938, this is the
20 witness statement of Dr Chris Williams, who I think
21 you're familiar with, and when we get there I'm going to
22 turn to page 6, paragraph 25.

23 What Dr Chris Williams states, about halfway down
24 this paragraph, is he refers to the availability of
25 other viewpoints on the wider questions being very
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1 particularly focused on it, and I think what Chris is
2 also alluding to is that when we'd got into the more
3 formative advice note stages. Mark would be part of
4 those discussions and we would have quite colourful
5 conversations because it was that balance of our health
6 protection saying, you know, "We need to be really
7 restrictive to prevent spread", and there's Mark saying,
8 "Well, there's the mental well-being and the different
9 aspects of the impacts on the population group".

10 So that was -- I think that's probably what Chris is
11 saying. But no, in the -- I would say in the -- in
12 January, February, March our focus was about trying to
13 prevent the spread of the infection, and then from April
14 we really started to increase our work on the broader
15 harms.

16 **Q.** I'm going to now look at INQ000056334, and this is
17 a Public Health Wales document from 10 March 2021, so
18 the following year, and at page 4, the second paragraph
19 from the bottom -- so this was -- the document itself
20 was a briefing note to the Minister for Health and
21 Social Services, and the second paragraph from the
22 bottom refers to:

23 "Further restrictions ... [Document read] ...
24 benefits and harms of such actions."

25 So why was the understanding of the harms caused by
211

1 helpful in moving beyond a strictly infection focused
2 assessment of harms and benefits.

3 Do you agree with that, and do you accept that the
4 focus ought also to have included the wider harms caused
5 by restrictions themselves?

6 **A.** If I can clarify your question, do you mean in relation
7 to what we were doing or in relation to what Wales was
8 doing?

9 **Q.** So do you agree that there was, at least initially,
10 a strictly infection based focus, and do you agree that
11 that ought to have considered the broader harms?

12 **A.** I think -- so if I answer for us, that's probably
13 easiest.

14 **Q.** Yes.

15 **A.** So I would say January, February, probably the first
16 part of March, it was absolutely about preventing --
17 protecting the public and preventing infection.
18 I mentioned earlier Professor Mark Bellis is one of our
19 former directors, so Mark very early on in the
20 pandemic -- he heads a department of WHO collaboration
21 centre -- was saying, "You've got to start to think
22 about the broader harms", which is why in April we
23 started doing that work. And so whilst it wasn't
24 necessarily appearing in our advice, there was a lot of
25 work that we'd put in train because Mark was
210

1 Covid-19 measures still, as of this time, so March 2021,
2 not sufficient?

3 **A.** Again, whether it's a question for us or a question for
4 Wales, I think where by March 2021 I think there was, to
5 be fair to Welsh Government, a -- much more of
6 a recognition around the harms in the way that they were
7 making the decisions, then it was the balance of --
8 around restrictions and the order of letting things or
9 releasing things.

10 I think for us I'm not sure that'll ever go away as
11 a statement. I think we know before we got into Covid
12 we were facing challenges and the demographics of
13 society, and then obviously since Covid we've had the
14 cost of living crisis, we've got the conflict in Ukraine
15 and climate change. So they all superimpose on the
16 broader harms, so I don't think we can ever do enough on
17 that.

18 But as far as the restrictions are concerned, it
19 was -- we obviously moved into a slightly different
20 world from March 2021, and what we were trying to
21 position Welsh Government to is to have a much more
22 structured way of tracking the numbers as well, because
23 we can talk about it but if you can't measure it, it's
24 quite challenging. Later in that year we developed
25 a much broader population health dashboard that included
212

1 all of the proxies into different parts of society --
 2 **Q.** Just focusing specifically on this timeframe and what
 3 this Public Health Wales document is saying, what steps
 4 were necessary in order to obtain the kind of more
 5 sophisticated understanding identified in this document?
 6 What kind of concrete things do you think this document
 7 is alluding to?

8 **A.** Yeah, I think it's measurement, and we kind of go on to
 9 say it in the document. So at the time there wasn't
 10 one, that we were aware of, centrally held point that
 11 was tracking the broader harms, be they about
 12 well-being, be they about impact on health services, be
 13 they about morbidity. So Welsh Government no doubt --
 14 and I'm not close to it -- had the socioeconomic
 15 tracking, but we weren't aware of anything that was
 16 actually measuring the specific harms around health and
 17 well-being.

18 Now, some of these take years to measure, to be
 19 fair, so it's not an easy thing to do. But our point
 20 really was more about, as we said in October 2020 -- we
 21 said this again, and this followed the meeting with the
 22 minister the previous fortnight -- that you'd got to
 23 start balancing them, and if the October 24th note that
 24 we sent was about getting into a different relationship
 25 with the public, in recognition of this, and factoring

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1 confusing or contradictory."

2 Do you accept that there was sometimes confusing
 3 guidance that was contradictory and unclear?

4 **A.** I think it was very confusing for care homes insofar as
 5 the guidance was changing very, very quickly and
 6 sometimes -- there was an occasion where a change to
 7 policy was announced and none of us knew it was going to
 8 be announced. So our call centres were going wild, and
 9 we didn't know it had been -- the decision had been
 10 made. So it was a -- it was a very busy time,
 11 particularly for care homes, I would say, around that
 12 February, March, April into May. So I would accept
 13 that.

14 **Q.** And specifically on visiting in care homes, do you
 15 accept that there were some deficiencies in visiting
 16 guidance and, if so, what kind of thing would be needed
 17 to ensure that guidance is clear, consistent and
 18 comprehensive in relation to visiting?

19 **A.** I'm not -- I can't recall exactly the specifics around
 20 visiting, I'm not as close to it. But we did put
 21 guidance -- I think guidance was circulated in March,
 22 middle of March, around really that trying to reduce the
 23 ingress of infection, sorry, from different sources but
 24 including visiting, and it probably wasn't until the
 25 middle of March, end of March where that changed.

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1 that into the pacing and the order of restrictions.

2 So this covered quite a few areas, I would say.

3 **Q.** Thank you.

4 Just moving to a slightly different topic around
 5 communication, you've explained today and in your
 6 statement about Public Health Wales' role about ensuring
 7 communication, ensuring the consistency (unclear).

8 If we could bring up document INQ000181725. While
 9 it comes up, I'll tell you what the document is.
 10 It's -- the Older People's Commissioner,
 11 Helena Herklots, produced a report called "*Care Home
 12 Voices: A snapshot of life in care homes in Wales during
 13 Covid-19*", and this is a document from June 2020, so
 14 fairly early on. And when we get there, I'll just refer
 15 to page 12 of this document and the first paragraph in
 16 particular of page 12.

17 What this paragraph says is that there were:

18 "A number of responses from care home managers and
 19 staff [highlighting] the difficulties ... in accessing
 20 crucial information and guidance ..."

21 And particularly the second sentence of this
 22 paragraph:

23 "Particular issues were highlighted about the amount
 24 of rapidly changing information that care homes were
 25 receiving, often from multiple bodies which was often

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1 I think there were areas with care homes that

2 I think we could have been clearer, Welsh Government
 3 could have been clearer, and I think we should have
 4 earlier on, whilst we set up an enclosed setting cell
 5 which was -- was the only port of support for the
 6 care home sector, I think we should have set up settings
 7 based meetings earlier so that we could really
 8 understand what the -- what was materialising on the
 9 ground within care homes. That would have been more
 10 helpful to have more or less guidance in; it may not
 11 have changed the public health advice. So, yeah,
 12 I would recognise that.

13 **Q.** Just on that, was there a member of the team who was
 14 responsible for producing guidance who fully understood
 15 the needs of people in care? And if there wasn't, do
 16 you think that that would be something that would be
 17 helpful going forward?

18 **A.** We had members -- we had a lot of members of the team in
 19 our enclosed setting cell, because we accelerated it
 20 very quickly, we had people who had quite a strong
 21 influence -- influence; experience around the care home
 22 setting. We did engage with particularly
 23 Care Inspectorate Wales, but I would absolutely agree
 24 with what you've said.

25 I guess what I'm alluding to is not just in care

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1 homes but, having reflected a lot on this, we were
2 working with partners but were -- but I think if we were
3 to run this again, I think we should have that settings
4 based, real lived experience people involved early on in
5 the development of guidance. As I say, it may not have
6 changed, it may not change the public health evidence,
7 but I thought this was a really powerful document, by
8 the way, and having read a lot from colleagues in
9 care homes the reality of: well, if you say to do X, do
10 you realise how challenging that is?

11 And then I guess my final point on this is all the
12 experience that care homes now have around infection
13 prevention and control, it's how do we help retain and
14 support that for people?

15 **Q.** Last week we heard from Stephanie Howarth, the
16 Chief Statistician, and she confirmed that the Knowledge
17 and Analytical Services only became involved in data
18 collection analysis after the early stage of the
19 pandemic and that if they had been asked to advise
20 earlier on, they could have avoided various errors and
21 misreporting. Why didn't Public Health Wales ask KAS to
22 assist at the outset of the pandemic?

23 **A.** We were just exponentially increasing our requests to
24 meet the demands from a data perspective from Welsh
25 Government. I guess -- I guess the question is they
217

1 said he couldn't recall whether he told the Welsh
2 Government but his main role was to keep Public Health
3 Wales updated.

4 Were you aware, was Public Health Wales told about
5 Dr Williams' awareness of possible asymptomatic
6 transmission in late February and, if so, what steps
7 were taken by Public Health Wales in relation to that?

8 **A.** Yeah, again, I think Quentin would be closer to it.
9 I wasn't part of the incident management team. I can't
10 imagine Chris wouldn't have shared that, I would have
11 thought, because we're -- everyone shares the evidence
12 because it would be -- you know, there's a duty to.
13 I would have thought -- although I didn't attend the
14 incident management team, which was a national incident
15 management team -- that, not just this but anything that
16 came through, there'd have been a discussion at various
17 times, because it was an evolving picture around
18 asymptomatic transmission, that that would have been
19 discussed and debated at the incident management team;
20 and any other further evidence that came through,
21 I would have thought that would have been debated there.

22 **MS FOUBISTER:** Thank you.

23 Thank you, my Lady.

24 **LADY HALLETT:** Thank you very much indeed.

25 Ms Jung, that completes the evidence for today?
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1 could have offered, you know, it's a bit of a two-way,
2 I would suggest. We were working really closely with
3 the Chief Scientific Officer for Health, with the NHS
4 delivery group who were looking at the activity data for
5 the NHS, who we tend to have those connections with. We
6 had worked less so with the knowledge and advisory
7 service, if I'm saying that correct.

8 So if we'd -- perhaps if we'd had a stronger
9 relationship with them, we would have thought to do it.
10 I did see the Chief Statistician for Health's evidence
11 and the -- part of the challenge, the flip side -- so if
12 we'd have thought, we'd have done it, but also it
13 would've been nice for them to offer. I think it was
14 probably incumbent on both parts.

15 But the challenge, though, is data's only as good as
16 it being populated at source, and we had some real
17 challenges on that for health and social care, so --

18 **Q.** Understood.

19 **A.** -- there's some human behaviours in there.

20 **Q.** I'll just move on, because I've got one final question
21 and I'm conscious of the time.

22 Last week, again, we heard from Dr Chris Williams
23 and he said that he was aware that asymptomatic
24 transmission could be as great as 40%, and this is
25 following the Diamond Princess cruise ship data, and he
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1 **MS JUNG:** It does, my Lady.

2 **LADY HALLETT:** Thank you very much indeed, Dr Cooper, very
3 grateful.

4 I'm afraid I'm not sure I can give you a guarantee
5 that you won't be asked to help again. I'll try to
6 limit it. I do understand the impositions that asking
7 people to give evidence makes upon them, apart from
8 anything else providing the statements and things, but
9 we're very conscious of it and will only call on your
10 help if we need it.

11 So thank you for what you've done so far.

12 **THE WITNESS:** Of course. Thank you.

13 **(The witness withdrew)**

14 **LADY HALLETT:** 10 o'clock tomorrow, please.

15 **(4.12 pm)**

16 **(The hearing adjourned until 10 am
17 on Wednesday, 6 March 2024)**

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