Witness Name: Dr Quentin Sandifer OBE

Position: Consultant Adviser - Pandemic and International Health

Statement No.: First

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UK COVID 19 INQUIRY
MODULE 2B

WITNESS STATEMENT OF DR QUENTIN SANDIFER OBE
FOR MODULE 2B

I, Dr Quentin Sandifer OBE, care of Public Health Wales, 2 Capital Quarter, Tyndall Street, Cardiff, CF10 4BZ

Will state:

1. For the period from October 2012 up until my retirement in December 2020, I was Executive Director for Public Health Services / Medical Director at Public Health Wales. This role included Executive level responsibility for Emergency Planning and Response. My last working day as an Executive Director was Friday 27 November 2020. After that date I had no further involvement with the response to COVID-19 by Public Health Wales.

2. Although now in retirement, I am currently engaged by Public Health Wales as a Consultant Adviser for Pandemic and International Health on a part time basis [further details in paragraph 15].

3. This Personal Witness Statement is provided by me in response to a Request for Evidence under Rule 9 of the Inquiry Rules 2006 dated 9 February 2023 (UK Covid-19 Inquiry reference M2B-PHW-QS-01).

4. Save for where it is stated otherwise, the contents of this Statement are within my own knowledge. This Statement is to the best of my knowledge and belief accurate and complete at the time of signing.

5. Whilst I understand the Inquiry is concerned with the period from 21 January 2020 until 30 May 2022, I am only able to provide my evidence up to my retirement in December 2020.

Background, Qualifications and Experience

6. Qualifications: I qualified as a medical doctor in 1985 from the University of Wales College of Medicine, Cardiff with undergraduate degrees, Bachelor in Medicine [MB] and Bachelor in Surgery [BCh]. Following pre-registration appointments, I have been a fully registered medical practitioner since 1986. My UK General Medical Council registration number is 3019195. Between October 1997 and December 2022, I was identified in the GMC register as a specialist in 'Public Health Medicine'. In December 2022 I relinquished my licence to (medical) practice but I continue to retain my name on the register.

7. I also have a Master's degree in Public Health from the University of Wales, Cardiff (1994), executive Masters degrees in Business Administration awarded separately by the London Business School (2005) and Columbia University School of Business, New York (2005), awarded following a programme delivered jointly by the two schools, membership by examination of the Royal College of General Practitioners (1989), and membership by examination of the Faculty of Public Health, Royal College of Physicians (1996).

8. In 2000 I was elected as a Fellow of the Royal College of General Practitioners and in 2004 I was elected as a Fellow of the Faculty of Public Health, Royal College of Physicians.

9. Following an Exercise Wales Gold in March 2015 I completed the Certificate in Leadership in Multi-Agency Emergency Response and Recovery Command and Co-ordination. This is a level 7 qualification awarded by Agored Cymru. Exercise Wales Gold provides an environment for exercising emergency scenarios by bringing together strategic leaders who would participate in a Strategic Co-ordinating Group (SCG) or a Recovery Co-ordinating Group (RCG) to respond to or recover from an emergency or major incident.

10. Career: Initially I trained in General Practice in the UK. Between 1990 and 1992 I practised as a Family Practitioner with hospital privileges in a rural community in western Canada. In 1992 I returned to the UK to undertake public health training based in Cardiff. From 1997 to 2004 I worked for a health authority/local health board in Wales, based in Swansea, first as a consultant in public health medicine and then as a director of public health.

11. Between 2004 and 2012 I worked for strategic health authorities, primary care trusts and local authorities in Southeast England and London in public health leadership roles, before returning to Wales in October 2012 to take up the post of Executive Director of Public Health Services and Medical Director for Public Health Wales.

12. The post of Executive Director of Public Health Services and Medical Director at Public Health Wales included responsibility for health protection and microbiology services provided by Public Health Wales, delivery of national screening programmes, strategic leadership for public health emergency planning, preparedness and response in Wales, executive oversight of medical staff employed by Public Health Wales, and oversight of public health training provided by the organisation. It is in this capacity that I am the author of the Corporate Witness Statement for Public Health Wales in Module 1.

13. From January to November 2020, I was also the Lead Strategic Director in Public Health Wales for the COVID-19 response. The role of strategic director is referred to later in my statement. For clarity the role of Lead Strategic Director had three components:

    - *strategic* leadership in the organisation on behalf of the executive directors and the board,
    - public health and medical *professional* leadership in Public Health Wales,
    - *co-ordination* of the response to COVID-19 on behalf of Public Health Wales.

14. In discharging this role, I was supported by the board of Public Health Wales, the chief executive and wider executive team members, and by lead professionals in health protection and microbiology.

15. Following my retirement in December 2020, in January 2021 I was re-engaged by Public Health Wales as a part-time consultant with the title Consultant Adviser on

Pandemic and International Health. The first part of the title anticipated the need foreseen by Public Health Wales for support to prepare for an expected public inquiry. The role did not require and therefore I did not have any involvement with the response to COVID-19 by Public Health Wales after 27 November 2020. Initially the focus of my role was to advise the International Health Division drawing on my relationships with the International Association for National Public Health Institutes (IANPHI) and WHO Europe. Following the announcement of a public inquiry by the Prime Minister in May 2021 I adjusted my sessional commitments to Public Health Wales to enable me to support the organisation as it began to prepare for the inquiry. In March 2022 I ceased my advisory role on International Health to focus on supporting Public Health Wales to respond to this Public Inquiry.

16. Experience: Since 2004 my public health career has oriented towards public health protection including screening. At Kent and Medway Strategic Health Authority, I was the executive lead responsible for overseeing the implementation by the NHS of the *Civil Contingencies Act 2004*. At NHS Southeast Coast I led for pandemic flu planning. During swine flu I was seconded to NHS London and the Department of Health to support the UK response including providing medical and public health input to the development of the National Pandemic Flu Service. In a joint appointment between NHS Camden (Camden PCT) and the London Borough of Camden I led the local public health emergency preparedness for the 2012 London Olympics, specifically with a focus on St. Pancras as an international port of entry.

17. Shortly after taking up my post at Public Health Wales, I coordinated the response to the measles outbreak in Wales (2012-2013). I oversaw the public health planning for and provided strategic input to the NATO Summit 2014 held in Newport, South Wales, acting as the Gold Commander for Public Health Wales during the event. Between 2014 and 2016 I coordinated the public health response to Ebola by the NHS in Wales.

18. Other experience: Between November 2014 and December 2020 I served as the lead executive director at Public Health Wales for the International Association of National Public Health Institutes (IANPHI). In April 2019 I was elected as the first Chair of the IANPHI European Regional Network (until 2021) and since May 2021 I have served as a Strategic Adviser to the IANPHI Executive Board. Further information about my involvement with IANPHI as it relates to Module 2B is set out at paragraph 137 below.

19. Publications: Over the past 20 years these have been limited to executive and commissioned reports. The latter includes the production of a Health Protection Policy Toolkit for the Commonwealth Secretariat, which was presented to the Commonwealth Health Ministers Meeting in 2016, and co-editorship of the IANPHI Report on the Lessons Learned from COVID-19, published in May 2022.

20. In 2021 I was appointed OBE in recognition of *"services to Public Health in Wales particularly during the Covid-19 Response"*.

Response to the pandemic January-March 2020

21. In my executive role at Public Health Wales, I first became aware of what later came to be known as COVID-19 on Wednesday 8 January 2020 when I was informed of the intention by the Health Protection service to publish a briefing note that day titled *Cluster of pneumonia of unknown aetiology in Wuhan city, China* [**Exhibit QS/1 INQ000147237**]. I was informed that this briefing was an adaptation of a briefing of the same title published in England by Public Health England (PHE) the previous day [**Exhibit QS/2 INQ000147248**]. The briefing was circulated to health protection and microbiology specialists in Public Health Wales, directors of public health, medical and nursing directors in health boards, and Welsh Government.

22. The following day, 9 January, I received an email from the Professional Lead Consultant for Health Protection at Public Health Wales enclosing a summary of an Incident Management Team (IMT) meeting convened by PHE that he had just attended [**Exhibit QS/3 INQ000147259**]. On Friday 10 January 2020 another briefing note was published by Public Health Wales titled *Pneumonia associated with a novel coronavirus, Wuhan, China* with the same circulation as the previous briefing [**Exhibit QS/4 INQ000147262**]. Health Protection staff continued to join daily IMTs led by PHE.

23. I briefed the Public Health Wales Business Executive Meeting on Monday 13 January and took an action to provide a briefing note to the Public Health Wales Board, which I sent to the Board, for information, on 16 January 2020. This included brief information on the first suspected case in Wales on 15 January (tested negative) [**Exhibit QS/5 INQ000147263**].

24. At this stage, the week commencing 13 January, I knew that Public Health Wales was engaged in discussions with the Welsh Government, principally via a Senior

Medical Officer (SMO) in the Office of the Chief Medical Officer for Wales (CMO Wales).

25. On 21 January, a meeting was held between Public Health Wales Health Protection and representatives of CMO Wales' office; my deputy attended for me. It was now becoming clearer that the resources necessary to input to the increasing number of meetings and actions arising out of the UK discussions on the incident in China, the need to be ready to respond to more suspected cases in Wales, and growing public awareness and need for a professional communication response from Public Health Wales were likely to exceed the normal operational capacity of the Health Protection service.

26. For these reasons, and on the advice of the Professional Lead Consultant for Health Protection, I invoked the Public Health Wales Emergency Response Plan at Enhanced Level on 22 January 2020 **[QS/5a INQ000056283]**. I was declared Strategic Director and the Professional Lead Consultant for Health Protection declared Incident Director. The responsibilities I assumed as the Strategic Director are set out on pages 28 and 29 of the Public Health Wales Emergency Response Plan then in force.

27. Invoking the Public Health Wales Emergency Response Plan just three weeks after China notified the WHO under the International Health Regulations was an exceptional decision for the organisation. We did not do this during the Middle East Respiratory Syndrome (MERS) outbreak in South Korea in 2015. Invoking the Plan not only recognised the growing demands on Public Health Wales to engage effectively in the UK response to the new disease but also the scale and speed of developments in China. Human-to-human transmission had been confirmed and the causative pathogen, a new (novel) coronavirus named 2019-nCoV, had already spread from Wuhan City, Hubei Province, where the first cases had been recorded, across much of China by 22 January 2020; on 21 January 2020 the Chinese Center for Disease Control and Prevention reported 270 cases confirmed from 13 (out of 23) mainland provinces. There were also five cases reported from neighbouring countries. Furthermore, although the risk to the UK population on 22 January was assessed as low, the risk for travellers to and from China was moderate, the travel links between China and western Europe and the UK had already been noted and the Chinese New Year was due to start on 25 January 2020 with significant travel within, to and from China expected.

28. The following day, 23 January, a Public Health Wales Incident Management Team (IMT) was set up to assess and manage the information and consequential actions arising from the PHE-led IMT, to undertake specific Welsh surveillance and risk assessment, and to provide public health technical advice on plans for responding to possible cases in Wales. An email from me to the Chief Executive of Public Health Wales summarised the new arrangements, the link to CMO Wales at Welsh Government, and the implications for executive management at Public Health Wales.

29. At the scheduled Board meeting on Thursday 23 January 2020, I provided a brief statement on the current situation in the public part of the meeting and presented a written report in the private session [**Exhibit QS/6 INQ000147264**]. My written report stated that "The number of queries and suspect cases (in the UK) are increasing…and it is increasingly likely that suspected cases will be identified in the UK, including Wales". The same day another briefing note was published by the Health Protection service at Public Health Wales and circulated, as before, to health protection and microbiology specialists in Public Health Wales, directors of public health, medical and nursing directors in health boards, and Welsh Government [**Exhibit 7 QS/7 INQ000147265**].

30. Following the occurrence of the first confirmed case in Europe on 24 January and a second suspected case in Wales on 25 January (also tested negative), a (tactical) Silver Group was established on 28 January to support the IMT. Having assessed the need, I decided not to establish a Gold Group at the same time (Gold Group was established 25 February 2020); both actions were consistent with the Public Health Wales Emergency Response Plan.

31. On Sunday 26 January 2020 I chaired a meeting between Welsh Government and Public Health Wales to agree strategic aims and actions. The CMO for Wales and a member of his team attended this meeting. The meeting identified and discussed five strategic aims:

    - Monitor and assess the risk to public health in Wales (as part of the UK response);
    - Facilitate detection, immediate case management and isolation to prevent transmission in Wales (as part of the UK response);
    - Develop a suitable diagnostic pathway for the novel strain;

- Provide robust guidance and information for health professionals and the public in Wales (as part of the UK response);
- Facilitate Public Health Wales and Welsh Government communications and action (cross-government, NHS Wales and wider partners).

32. After 26 January 2020, informal meetings were established between the executive leads at Public Health Wales and the CMO. Occasionally the CMO would be accompanied by members of his team at these meetings. These meetings, which happened two or three times a week, enabled sharing of information and early notice of advice to and requests from Welsh Government.

33. At the Public Health Wales Business Executive Meeting the following day, 27 January 2020, I reported on the outcome of the meeting with Welsh Government (represented by CMO), the implications for the executive team following the decision the previous week to put the organisation on an 'enhanced level' of emergency response whilst not (yet) establishing a Gold Group, and an update on other business including the imminent deadline for the UK exit from the EU and the associated work Public Health Wales was still undertaking. Two additional back up strategic directors were agreed to support me.

34. During the week commencing 27 January 2020 the momentum changed. Public Health Wales was now undertaking assessment and testing of suspected cases across Wales with only a limited Health Protection resource available. I therefore issued an organisation-wide call for staff to strengthen the health protection response. Within a week this had attracted over 70 volunteers.

35. Following the WHO declaration on 30 January 2020 that COVID-19 met the criteria of being a Public Health Emergency of International Concern (PHEIC) and the announcement of the first confirmed cases in the UK on 31 January 2020, I sent an email to the Public Health Wales executive informing them of the situation, prepared a media statement [**Exhibit QS/8 INQ000147266**], sent another briefing note to the members of the Public Health Wales Board [**Exhibit QS/9 INQ000147267**], and organised an open meeting with our staff co-chaired by myself and the Chief Executive. Over 200 staff attended, mainly online.

36. At the end of January / start of February 2020 Public Health Wales was assessing and sampling patients across Wales and turnaround times for laboratory testing undertaken at a laboratory in London (Colindale) were already approaching 48

hours. I therefore took part in discussions between Public Health Wales' Microbiology service, the CMO Wales and PHE on establishing a test to be undertaken in the Public Health Wales laboratory at the University Hospital of Wales, Cardiff. As a result, a test was approved by CMO Wales on 7 February 2020 and parallel PHE testing ceased after that date. The establishment of a laboratory test undertaken in Cardiff reduced laboratory turnaround times from 48 hours to a few hours (depending on time of sample receipt by the laboratory and need for sample batching).

37. The challenge now returned to community sampling and the continued dependence of the NHS in Wales on the small number of infectious disease doctors from Public Health Wales going out to assess patients either in local hospitals or in the community.

38. In the last week of January and early February 2020 I joined meetings convened by the Public Health Wales Microbiology Head of Operations and National Clinical Lead with health boards in Wales to discuss community testing and the concept of Coronavirus Testing Units. Concern that I, and others in Public Health Wales, had about the progress being made resulted in a letter being issued by CMO Wales on 10 February 2020 requesting "*that every health board develops community assessment and testing plans*" and "*each health board must have "Coronavirus Testing Units" separate from Emergency Departments for any members of the public who may arrive on site concerned that they have symptoms consistent with coronavirus*" [**Exhibit QS/10 INQ000147238**]. The letter went on to state that these arrangements needed to "*be operational as soon as practically possible and by no later than Friday 14 February*". I also joined a series of meetings organised by the Chief Executive of Public Health Wales with health boards and trusts in Wales in mid-February.

39. In early February I also contributed to the production of a flowchart setting out the pathway for the "Management of a suspected case of 2019-nCoV acute respiratory disease", which was published by Welsh Government on 10 February 2020 [**Exhibit QS/11 INQ000147239**]. A month later I contributed to the production of a protocol for notifying and announcing a confirmed death from COVID-19 in Wales [**Exhibit QS/12 INQ000147240**].

40. On 18 February I was invited to attend the first meeting of the Welsh Government Health and Social Services Group (H&SSG) Coronavirus Planning & Response

Group scheduled for Friday 20 February 2020. I attended this and nearly all subsequent meetings of this Group over the next nine months. At these meetings I would present a situation report and answer questions on behalf of Public Health Wales.

41. Noting with concern the situation in Italy, I chaired a meeting on 24 February attended by the CMO Wales and the Chief Executive, other executives and senior health protection staff from Public Health Wales. The meeting agreed to maintain a containment strategy, with the intention to limit human-to-human transmission including reducing secondary infections among close contacts and health care workers. At that date there had not yet been a confirmed case in Wales but health protection staff emphasised that confirmed cases were highly likely in Wales as a result of the epidemic progression and better understanding of transmission dynamics. The meeting also agreed to stand up the Public Health Wales Gold Group under my chairmanship as lead Strategic Director.

42. I chaired the first meeting of the Public Health Wales Gold Group on 25 February 2020 with the primary objective at that time of mobilising internal staff resources to support the response. The number of calls received by the National Contact Centre had increased exponentially over the previous three weeks, principally in response to changes in case definition.

43. The Gold Group assumed overall responsibility for the management of the response to COVID-19 by Public Health Wales. Between April and June 2020, the Gold meeting also subsumed the executive team meeting. I chaired the majority of the Gold meetings up to the end of November 2020 in my role as Lead Strategic Director except those during April, May and early June, which were chaired by the Chief Executive of Public Health Wales. The Gold Group received regular updates from the Public Health Wales IMT and representatives to Welsh Government Advisory Groups and was the forum for strategic discussion in response to actions and requests received from Welsh Government.

44. On 27 February 2020, Public Health Wales responded to the first confirmed case of COVID-19 in Wales, supporting Welsh Government.

45. At the start of March 2020 work was already underway at UK level to model and plan for the next phase of the outbreak, that is, post containment. Devolved Administrations were involved in this work. Public Health Wales had already

anticipated this when it met with CMO Wales on 24 February 2020; advice then from the Professional Lead Consultant for Health Protection, in the form of a discussion paper, was that: "*When there is evidence of sustained community transmission with second and third generation cases, the containment strategic (sic) is highly unlikely to be effective and a shift in strategic aim to one of "management" is recommended based on previous experience of large scale, multi-country outbreaks caused by respiratory pathogens that spread by droplet route*" [**Exhibit QS/13 INQ000147241**].

46. In the first three weeks of March, I could see confirmed case numbers in Wales starting to take off; at the H&SSG Coronavirus Planning & Response Group meetings on 6, 13 and 20 March I reported the cumulative confirmed case numbers in Wales as 2, 35 and 191 respectively.

47. It was no surprise to me therefore when, on 12 March, Wales and the rest of the UK, moved from the 'containment' phase to the 'delay' phase of the response to COVID-19. At this date health protection staff assessed that the epidemiological situation in Wales was about one week behind England and though there was some debate about whether there was *sustained* community transmission – the threshold for moving from containment to delay – the numbers clearly showed that if we weren't there yet, this was only a matter of time. Furthermore, it was by then clear that Public Health Wales' capacity to conduct contact tracing was reaching a limit without a large expansion in the workforce to undertake this activity.

48. The issue of scaling up human resources is identified in the Public Health Wales Corporate Statement for Module 2B as one of the challenges it faced in responding to the pandemic. In the first three weeks of the pandemic, that is, to the end of January 2020, when there were no cases in the UK, the response was staffed by the Health Protection and Microbiology Divisions at Public Health Wales. I issued a call for volunteers on 27 January, reissued that call at an 'open' meeting convened on 31 January, again issued a call on 7 and 10 February, and alerted staff of a likely need for further mobilisation in an all-staff communication issued 21 February. Calls to the National Contact Centre increased exponentially in February and a workforce plan was developed with a further call to staff on 28 February. Nevertheless, despite the numbers of staff coming forward, confronted by increasing confirmed case numbers in early March, it became clear to me that the ability of the organisation to respond to enquiries and conduct contact tracing was nearing its limit. I comment on my learning from this experience in paragraphs 155 and 156.

49. Meetings I attended on 12 March 2020 included:

- An extraordinary Gold meeting that I chaired to discuss a paper from health protection staff at Public Health Wales setting out their thoughts on the considerations arising out of a move to a post-containment phase in the response. I shared this paper with CMO Wales and the Director General Health and Social Services/ NHS Wales Chief Executive [**Exhibit QS/14**[1] **INQ000147242**].

- A meeting between the Chief Executive of Public Health Wales and the Director General Health and Social Services/ NHS Wales Chief Executive at the Public Health Wales' office.

- An urgent conference call with the Chief Executive of Public Health Wales and the NHS Wales Chief Executives' Management Team followed by an extraordinary conference call with all the health boards and trusts in Wales to discuss the policy changes and their implications.

50. On 13 March 2020 I accompanied the Minister for Health and Social Services on a pre-arranged tour of the Public Health Wales Contact Centre. Other meetings I attended on 13 March included:

- A Gold meeting that I chaired to discuss a recommendation from health protection and microbiology professional leads to stop routine community testing, close down contact tracing (in a managed way so as not to leave vulnerable people exposed) and ramp up hospital testing to support cohorting of patients based on agreed criteria. This recommendation followed the publication of a CMO Wales Public Health Link letter, setting out the actions needed as Wales moved to the 'delay phase' of the COVID-19 response [**Exhibit QS/15 INQ000147243**]. This was followed by a meeting I attended with health boards to explain the actions Public Health Wales was proposing to take. After this meeting Public Health Wales confirmed its approach to Welsh Government.

51. Following the decision by Welsh Government to reprioritise NHS services to support the Covid response, the Screening Division at Public Health Wales, in response to a request from me, prepared advice on what screening programmes could be

[1] I have not been able to find any other version of this paper and to the best of my knowledge, it seems no final paper was published.

suspended [**Exhibit QS/16 INQ000147244**]. Their advice was presented to me and to Welsh Government on 17 March 2020. The recommendation to suspend some of the screening programmes was approved by CMO Wales on 19 March, with a requirement to review in eight weeks. Similarly, decisions were taken by Welsh Government on the recommendation of Public Health Wales with regard to vaccination programmes in Wales. This followed discussions at the Public Health Wales Gold meeting on 27 March.

Specific points related to the period January-March 2020

52. Access to scientific information: I am unable to comment on whether the Welsh Government was in any way curtailed or prevented from understanding the full scientific picture between January to March 2020 due to its access or lack of access to the medical and scientific advice being provided to the UK Government. In the first few months of the pandemic, Public Health Wales did not have any access to the deliberations (papers and discussions) of the Scientific Advisory Group for Emergencies (SAGE) until the Welsh Government, through its Chief Scientific Adviser for Health, secured a formal mechanism by which Public Health Wales would be better sighted on technical information from SAGE. I had no direct involvement in these discussions.

53. Herd immunity: My understanding of 'herd immunity' is that it is the protection acquired in a population from an infectious disease either through vaccination or through previous infection. As a public health professional, I favour achieving 'herd immunity' through vaccination and not by allowing an infectious disease to spread through the population, as this would result in unnecessary cases and avoidable harms including death. In the first months of the pandemic there was no vaccine available. Therefore, from my perspective, the priority was to prevent disease transmission and protect those most likely to be vulnerable while a new vaccine was developed.

54. To the best of my recollection and my personal review of the records available to me the concept of "herd immunity" and its strategic significance was not discussed with Public Health Wales. I was not party to any discussions that may, or may not, have taken place within Welsh Government or between Welsh Government and others.

55. When Public Health Wales met with CMO Wales on 26 January 2020 to discuss the strategic approach to take, 'herd-immunity' was not discussed nor was it discussed in subsequent meetings between Public Health Wales and Welsh Government. The strategic approach that was agreed at this meeting between Public Health Wales and Welsh Government, represented by the CMO Wales, is set out in paragraph 31.

56. Wales co-ordination: In January 2020, Public Health Wales asked Welsh Government whether they were going to stand up the Emergency Co-ordination Centre (Wales) [ECC(W)]. In an email I received dated 24 January 2020, from a Welsh Government official, I was informed that they didn't "*see this event as it is currently moving from being in the public health outbreak management space and into civil contingency/multi-agency emergency response*" [**Exhibit QS/17 INQ000147245**]. This position was restated on 3 March in an email from Welsh Government. **[Exhibit QS/17a INQ000255778].** On 11 March 2020, the date the WHO declared COVID-19 a pandemic, Public Health Wales drafted a paper summarising the current situation and providing an evidential summary of considerations to guide Welsh Government in any decision on the declaration of a Major Incident for Health in Wales [**Exhibit QS/18 INQ000147246**]. Feedback from Welsh Government was that such a declaration would not be helpful.

57. The email dated 24 January 2020 from the Welsh Government official [**Exhibit QS/17 INQ000147245 as above**] also stated that "*Public Health Wales is part of the LRF structure and have in the past arranged a Wales briefing of LRF partners, facilitated by Quentin. This was at the height of the EBOLA risk and I don't think we are at that point. If necessary, PHW could consider a similar approach to briefing LRF representatives*". This refers to the Public Health Wales Public Health Strategic Co-ordinating Support Group (PHSCSG). In March 2020 I established the PHSCSG, which met for the first time on 23 March 2020 (see paragraph 85).

58. Divergence between Welsh and UK Government: In personal discussions I had with the CMO in the first weeks of the pandemic he asked that the response taken by Public Health Wales should be consistent with that being applied by the UK Government, and specifically in England, except where specific structural or cultural differences applied, for example, delivery of public health and the organisation of the NHS in Wales, and use of the Welsh language. This made sense in the early stages of the pandemic when all four countries, and not just Wales and England, were still assessing the threat from COVID-19 and mobilising their health and social care systems in response.

59. Divergence between Wales and England only really became apparent in early May 2020 when Welsh Government set out its approach to lifting restrictions (the national lockdown). I am not in a position to comment on the precise reasons informing the difference in approach taken by Welsh Government on this or other matters where there were differences between Wales and England. In relation to the ending of the national lockdown, I was concerned at the speed the UK Government was lifting restrictions in England and I think the more cautious approach taken by the Welsh Government on this, and other policy decisions, worked well.

60. In consideration of the broader question about whether divergence between Welsh Government and the other nations in the UK was necessary, I note that Wales had experienced two decades of devolution before the onset of the pandemic. As a result, Wales had established distinct and different legislation and policies, for example, the Well-being of Future Generations (Wales) Act 2015, and different structures and processes for the delivery of its public services including healthcare and public health. For example, Public Health Wales was an NHS trust accountable to Welsh Government and not an executive agency of Government.

61. These differences existed before the pandemic and as such I was familiar with the need to adapt any health policy that was common to all parts of the UK to the legislative context, policies, and organisational structures and management systems in place in Wales. This necessity existed before any consideration of differences in the characteristics of the population and the epidemiology of the health issue under consideration.

62. When all of these considerations are taken together and observing the differences across the UK in the epidemiology of COVID-19 from time to time, it is my view that divergence between the responses from the four administrations across the UK was always likely. Whether and when different approaches taken elsewhere in response to COVID-19 worked better than those taken by the Welsh Government is not something I am able to comment on.

63. Legislation: With the exception described in the next paragraph, I did not have any direct role in providing advice to the First Minister, the Welsh Government, and its representatives, on the public health and coronavirus legislation and regulations. However, I did see and confirm support for a recommendation from the CMO Wales' office that COVID-19 should be made a notifiable disease.

64. The only exception to my statement in the preceding paragraph was in regard to draft Health Protection (Coronavirus) Regulations 2020 that Welsh Government shared with Public Health Wales on 10 February 2020 for comment, and specifically the proposal to use public health professionals to enforce legislative compliance. I wrote a briefing note to the CMO interpreting the new regulations and drawing attention to the human (public) health, professional, organisational and societal issues raised by the regulations [**Exhibit QS/19 INQ000147247**]. In my note I reminded Welsh Government of the existing legislation in place and the option of using existing powers, Health Protection (Part 2A Orders) (Wales) Regulations 2010, with enhancement to the process for its use. A Part 2A Order is an order made by a Justice of the Peace (magistrate), on application from a local authority, under the Public Health (Control of Disease) Act 1984, as amended by the Health and Social Care Act 2008, imposing restrictions or requirements for the purposes of protecting human health.

65. In response, the CMO asked Public Health Wales to work with Welsh Government officials to develop amendments to the protocol in place for the existing regulations in Wales, specifically to enable a response commensurate with the urgency associated with Coronavirus. This led to a new agreed protocol for the use of Part 2A Orders, following legal scrutiny and by agreement with the Chief Magistrate, health boards and local authorities in Wales, which was published 6 March 2020 [**Exhibit QS/20 INQ000147249**].

66. First national lockdown March 2020: The concept of applying restrictions to populations to control infectious disease outbreaks is well established historically. Observing the situation in Northern Italy in the second half of February 2020 and noting that the first confirmed case in Wales was in a traveller returning from Northern Italy, I had no doubt at the end of February 2020 that restrictions of some type would become necessary in Wales. What form the restrictions should take, when they should be applied and for how long was then a matter of judgement.

67. I was not involved in any discussions leading to the decision to impose national restrictions in Wales. However, I could see what was happening. I had access to epidemiological data and I could see the exponential rise in case numbers in Wales during the week ending 13 March. Therefore, *instinctively* I felt that a lockdown as announced in the UK on 23 March should have happened a week or perhaps 10 days earlier. In answering the question about the length of the lockdown, as well as indicators of disease transmission, I did not think we could lift restrictions until we

had established, at scale, the necessary testing *and* contact tracing capacity in Wales to deal with any subsequent increase in case numbers. This second point was endorsed by SAGE and was not achieved in Wales until the start of June. This coincided with the duration of the lockdown in Wales.

Decision-making and advice provided to Welsh Government

68. My role in key decisions taken by Welsh Government: Throughout the period of my involvement in the response to COVID-19, I was always clear in my mind that decisions were for Welsh Government. The role of Public Health Wales, as the national public health institute in Wales, was to provide Welsh Government with independent, science-based data, information, and advice that could assist decision-making by Welsh Government. I was also very clear in my mind that Welsh Government would also receive data, information and advice from other sources and that I might not know about some of the information and advice provided by others, or even how much of our advice might have been used by Welsh Government when making decisions.

69. Meetings dealing with or impacting upon Welsh Government's response: I attended very few *decision-making* committees, groups or forums dealing with or impacting upon the Welsh Government's response to COVID-19. The only exceptions were meetings to consider whether to introduce local or regional restrictions or to advise on a specific policy matter. I refer to these in paragraphs 72 and 73. However, I did attend meetings where I provided *advice* or *briefings*

70. In this section of the statement, I describe some of the meetings I attended and for completeness I refer to meetings at UK level, that dealt with or impacted on the Welsh Government's response to COVID-19.

71. Senedd Health, Social Care and Sport Committee: Together with the Chief Executive of Public Health Wales and the Professional Lead Consultant for Health Protection, I was invited to attend three hearings of this Committee, on 7 May, 12 June and 23 September 2020. At these meetings I gave evidence on COVID-19, our experience and learning. It was my impression that the outcome of these hearings, first published as a report in July 2020 [**Exhibit QS/21 INQ000147250**], informed the future direction taken by Welsh Government in response to COVID-19.

72. Ministerial meetings: I attended very few meetings with the First or Health Minister. Usually, I would be one of many attendees including other staff from Public Health

Wales, for example, meetings of the Test Trace Protect Programme Board (chaired by a Welsh Government official and attended in the first few weeks by the Health and Social Services Minister) and meetings in September 2020 where local restrictions were discussed between local government (leaders and officials) and Welsh Government (including the First and Health Minister).

73. An example of a meeting that I attended specifically at the request of the First or Health and Social Services Minister, which informed a decision taken by Welsh Government was a meeting with the First Minister on 23 June 2020 to discuss follow-up monitoring arrangements for Welsh resident travellers returning to Wales (further information is provided in paragraphs 98-101).

74. Meetings with the Chief Medical Officer (CMO) for Wales: I attended meetings with CMO Wales that were held from time to time to discuss specific matters requiring decision, for example, strategic aims (26 January and 24 February 2020) and the plan for recovery after the first lockdown (several in April 2020). The first of these was a forum where I and others from Public Health Wales provided advice that informed the strategic approach that was adopted in Wales in the first phase of the pandemic, having been agreed between Public Health Wales and CMO Wales. I am unable to confirm if this was subject to any decision-making process within Welsh Government. The second occurred in response to a request from CMO Wales to Public Health Wales for a plan for recovery (paragraphs 93-95). The eventual outcome was the National Health Protection Response Plan submitted to CMO Wales on 4 May 2020 **[Exhibit QS/21b INQ000056350]**. I believe that this Plan informed the decision by Welsh Government on the approach to the second phase of the pandemic and published as the Test Trace Protect strategy.

75. Health Protection Advisory Group (HPAG): The HPAG is a non-statutory committee established and chaired by the CMO for Wales. I had served on the Group under previous Welsh CMOs but shortly after the current CMO was appointed the Group went into abeyance to be re-established in early 2018. The stated mandate for the HPAG on its re-establishment was "*to secure wide integration and effective implementation of health protection policies, maintain an overview of the work of health protection and drive forward the health protection agenda in Wales*". The last meeting of the HPAG before the onset of the pandemic was in December 2019.

76. The first time the HPAG met in 2020 was on 7 July. The Group agreed to meet monthly although this changed to fortnightly in the autumn and continued as such to the date of my retirement.

77. Although not a decision-making forum but rather an advisory group, HPAG nevertheless informed decisions made by Welsh Government, as reflected in amended terms of reference that were agreed at the next meeting on 11 August 2020 [**Exhibit QS/22 INQ000147251**]:

- "*HPAG will provide a national all Wales level oversight of the national health escalation and response plan.*

- *HPAG will review advice, evidence and information to make recommendations on escalation to Ministers, who will make any decisions about the need for national intervention. This might include national lockdown restrictions, or the creation of regulations for local or regional lockdowns. These decisions will be informed by a wide range of advice on the proportionality and impact of restrictions, ensuring that public health objectives can be achieved whilst minimising wider harms. Any decisions or regulations will need to be kept under continuous review to ensure that they remain proportionate and that any restrictions are removed as soon as they are no longer so. Any decisions by Welsh Ministers will be communicated with all other tiers (Silver and Bronze) to ensure continued coordination of response efforts.*

- *HPAG will advise and update Minsters on the incidence of COVID-19, the scale and nature of any local outbreaks and their management arrangements, including any arrangements to recognise cross-border risks.*

- *HPAG will coordinate cross Welsh Government action on local containment measures, such as in sectors such as education, the economy, or social care*".

78. Public Health Wales health protection staff used these amended terms of reference to guide their continued relationship with the Office of the CMO Wales. I detail in paragraphs 108-112 how I was involved in advising through the HPAG on the need for and the development of Local Prevention and Response Plans that informed decisions by Welsh Government.

79. <u>H&SSG Coronavirus Planning & Response Group later known as the COVID-19 Planning and Response Group</u>: The invitation to join this meeting stated that the

"*purpose of the Group will be to provide strategic co-ordination and support to NHS Wales and Social Services through the phases of the coronavirus infection (COVID-19), particularly in the contingency planning for the reasonable worst case scenario, as agreed by the Scientific Advisory Group for Emergencies (SAGE)*".

80. The invitation went on to state that "*The Group will report to Andrew Goodall and Frank Atherton (CMO) and its activities will: Ensure co-ordination and communication between organisations; enable information sharing; identify key actions to be taken; and assess delivery risks and mitigating actions*".

81. The first meeting took place on 20 February 2020. I attended this and most of the meetings of this Group until my retirement. At these meetings I would present a situation report, answer questions and provide advice on behalf of Public Health Wales. Like the HPAG, very few decisions were made by the H&SSG Coronavirus Planning & Response Group, though some decisions were confirmed on behalf of Welsh Government at these meetings, for example, application of infection prevention and control (IPC) guidance in healthcare settings.

82. Test Trace Protect (TTP) Programme Oversight Group (Programme Board): This meeting was established by Welsh Government to oversee the implementation of its TTP strategy published on 13 May 2020. The Group was chaired by an official from Welsh Government and included members representing Welsh Government, health boards (usually represented by directors of public health), and representatives from other organisations or entities including the NHS Wales Informatics Service and directors of public protection. Public Health Wales attendance was wide-ranging but usually included myself, the Chief Executive of Public Health Wales, and the Professional Lead Consultants for Health Protection and Microbiology. I attended the first and most meetings of the Group between May and November 2020. The Minister for Health and Social Services attended many of the meetings of the Group in the first few weeks. At these meetings I would answer questions and provide advice on behalf of Public Health Wales however, most the of the discussion, and any decisions made, were at a technical or operational level and informed by input from professional leads in Public Health Wales, for example, on the information technology solution to support TTP.

83. COVID-19 Mortality Review Meetings: In early April 2020, as part of a range of enhanced surveillance measures, and to ensure timely reporting, Public Health Wales with NHS Wales Informatics Service developed an electronic (e-form) to

facilitate reporting COVID-19 deaths in hospitalised patients. Following the identification of 84 deaths that had not been reported by one health board, and a further 31 unreported deaths from another health board, Welsh Government conducted a rapid review. This led to the establishment of weekly COVID-19 Mortality Review meetings, which I co-chaired with the Chief Statistician for Welsh Government. These meetings were attended by medical directors or their nominated representative from all the health boards and trusts in Wales. Although not a decision-making forum, the meeting fulfilled the important function of whole-system oversight of compliance with reporting protocols as recommended by the Welsh Government review. The meetings commenced late April, moved from weekly to fortnightly mid-June and were still taking place when I retired.

84. In all the meetings described in paragraphs 69-83 I contributed my professional knowledge, experience and views in my role as Lead Strategic Director for Public Health Wales. This included making presentations to meetings, responding to questions in discussions, preparation of reports as requested or in support of comments and advice given, and responding to requests for information.

85. Other external meetings: Public Health Wales Public Health Strategic Co-ordination Support Group (PHSCSG). This group, which I set up in March 2020 and chaired up to the end of November 2020, in my role as Lead Strategic Director, was established primarily to facilitate multi-agency strategic discussions and Welsh Government officials regularly attended, provided updates and used the group as a forum for discussing matters dealing with their response to the pandemic. For example, the Chief Veterinary Officer for Wales used the PHSCSG as a forum for discussing the risks and mitigations associated with food processing plants following COVID-19 outbreaks at several plants in June 2020.

86. UK meetings: I attended meetings on an *ad hoc* basis and also received occasional calls from UK Government officials to discuss specific matters, for example, from a Deputy Chief Medical Officer for England in March 2020 to discuss mass testing and the type of test the Public Health Wales laboratory was using.

87. In June 2020 I participated in several discussions with the Foreign, Commonwealth and Development Office and Home Office, facilitated by Welsh Government, on how, through Welsh Government, Public Health Wales could obtain data on travellers to Wales. This was in response to the introduction of border controls and

the requirements on Public Health Wales set by Welsh Government (paragraphs 98-101).

88. In June and July 2020, I attended several online meetings with PHE relating to the plan to establish the Joint Biosecurity Centre (JBC). I have no information on how my contributions to these meetings informed subsequent decisions taken by Welsh Government, if indeed they did.

Working with Welsh Government

89. Recognition and first response by Welsh Government: Early in January 2020, at the same time as Public Health Wales first learnt of the novel Coronavirus in China, a senior medical officer at Welsh Government leading for health protection, Dr Marion Lyons, also joined the PHE-led IMT established on 9 January and over the following two weeks Public Health Wales continued to engage actively with the Office of the CMO for Wales at Welsh Government. My impression then, and now, was that the CMO for Wales recognised the seriousness of the threat from the novel coronavirus infection being reported in China from the outset. At this stage the understanding of the threat and the activities in response across the rest of Welsh Government, beyond the Office of the CMO for Wales, was not apparent to me.

90. Approaches to and advice given by Public Health Wales between January and March 2020: On 26 January 2020, Public Health Wales met with the CMO for Wales at a meeting that I chaired, which agreed the strategic aims for the response in Wales to the emerging threat (paragraph 31). This followed discussions between Public Health Wales and the CMO's staff about a strategic plan for Wales.

91. From Monday 27 January 2020 Welsh Government via the Office of the CMO Wales started sharing a note of a regular meeting established and led, as I understood, by the Department of Health and Social Care (DHSC) (Wuhan Novel Coronavirus Incident National Co-ordination meeting). The notes of this inter-governmental meeting helpfully provided Public Health Wales with additional insight into the approach being developed by the UK Government and informed subsequent discussions between Public Health Wales and CMO Wales and his staff. At the same time Public Health Wales began to have regular informal discussions with the CMO.

92. As described earlier, Public Health Wales continued to work closely with the CMO Wales throughout the first stage of the pandemic providing advice on a range of

matters. Those I had involvement in included the provision of advice on sampling and testing of suspected cases in January and February 2020, establishing a testing capability in Cardiff, developing high consequence infectious disease facilities in Wales, the use of enhanced Part 2A Orders as an alternative to proposals set out in draft legislation, a pathway for the "Management of a suspected case of 2019-nCoV acute respiratory disease", and a protocol for notifying and announcing a confirmed death from COVID-19 in Wales.

93. Recovery planning: In April 2020 CMO Wales asked Public Health Wales for advice on 'recovery planning'. In fact, although referred to as such, at this stage of the pandemic this was not about recovery from the pandemic but planning for the next stage of the pandemic, and specifically following the lifting of the national lockdown. This was followed by a formal request in a letter from CMO Wales to the Chief Executive of Public Health Wales dated 22 April 2020 [**Exhibit QS/23 INQ000147252**]. I attended several internal meetings and, following receipt of the letter, led an internal process that prepared the National Health Protection Response Plan, which was submitted to the CMO on 4 May 2020.

94. The National Health Protection Response Plan, later foreshortened to National Health Protection Plan, outlined three major activities "for concerted public health action at scale" including: preventing the spread of disease through contact tracing and case management; population surveillance; and sampling and testing. The Plan drew on the best scientific evidence then available, past and projected epidemiology and international learning. It emphasised the need for contact tracing to be led by local authorities and health boards to achieve the scale required.

95. Following a rapid consultation with key stakeholders in local government and the NHS, Welsh Government published its Test Trace Protect (TTP) strategy on 13 May 2020 [**Exhibit QS/24 INQ000147253**]. A TTP Programme Board was quickly established, chaired by a Welsh Government official; I joined this Board at its inception and remained an active member during the remainder of my time as Lead Strategic Director for Public Health Wales.

96. Other advice provided to Welsh Government: In this section I set out some examples where I was involved in the preparation and provision of advice to Welsh Government following the initial phase of the pandemic (January-March 2020).

97. Test Trace Protect (TTP): My principal contribution to the TTP programme was to provide comment and advice based on professional knowledge and experience in my role as Lead Strategic Director for Public Health Wales. Areas I provided advice on included the development of the digital platform to support TTP, the role of TTP in support of the requirements set by Welsh Government for travellers (returning or otherwise) to Wales from abroad and responding to increases in case numbers in September and October 2020.

98. Border controls: Following an announcement by the UK Government on 11 May 2020, regulations were developed in each of the four nations to cover a range of measures and restrictions that were to be introduced at the UK borders from 8 June 2020.

99. Although I was aware of this proposal and had some discussions with Welsh Government in May, I was not involved in the preparation of guidance and I was therefore surprised by the specific request in an email from Welsh Government dated 31 May 2020 [**Exhibit QS/25 INQ000147254**]. This included an expectation of Public Health Wales that, having received data from the Home Office, it would write to all overseas travellers by recorded delivery letter, followed by telephone contact for monitoring.

100. In response I wrote back pointing out two difficulties. First, I had to remind Welsh Government officials that Public Health Wales informatics staff, as NHS employees and not government employees, could not access the Passenger Locator Form database held by the Home Office. Second, I had to draw attention to the operational requirements to deliver the specification for the request, namely, to send out about 150 recorded delivery letters a day – the number based on agreed estimates of traveller numbers expected during the summer – followed by daily phone calls for 14 days to each arrival.

101. This was followed by discussions between Public Health Wales and Welsh Government, led by one of the health protection consultants, with frequent interventions by me, and was finally resolved in a meeting I attended with the First Minister on 23 June 2020 where I advised that we send public health information to all travellers by email using Notify.Gov, to allow batching, and limited follow up phone calls to a sample of travellers. The First Minister accepted this advice.

102. Outbreaks during the summer of 2020: Although case numbers fell after the first wave in April 2020 and remained low in the first few weeks after the national lockdown restrictions were lifted, it wasn't long before local outbreaks arose. Some of these were in specific settings including food processing plants and hospitals. Other local outbreaks were dealt with by local incident management teams set up in accordance with The Communicable Disease Outbreak Plan for Wales, which was revised in June/July 2020. . **[EXHIBIT QS/25a INQ000089575 and EXHIBIT QS/25b INQ000409841**

103. I was closely involved in discussions about some of the settings-based outbreaks and briefly refer to these now.

104. Outbreaks centred on meat and food processing sites in Wales: Three outbreaks were declared centred around meat and food processing sites in Wales in June and July 2020. The first was at a food processing plant in Anglesey, the second at a plant near Wrexham and the third at a meat processing plant in Merthyr Tydfil. All three attracted national political and media attention. This included a meeting held on 22 June that I attended with the Chief Executive and health protection staff from Public Health Wales with the Health and Social Services Minister, local government and health boards. On request from individual local authority leaders and officials, meetings were arranged that I attended together with the Chief Executive of Public Health Wales and health protection staff. I also arranged a special multi-agency meeting to discuss the roles, responsibilities, risks and actions, from which guidance was drafted.

105. Outbreaks in hospitals in Wales: Two hospital outbreaks occurred in July 2020 that attracted national political and media attention. One occurred at Wrexham Maelor Hospital and the other at the Royal Glamorgan Hospital. The Royal Glamorgan Hospital outbreak was dealt with very quickly. The Wrexham Maelor outbreak proved more challenging and required significant input from infection prevention control staff from Public Health Wales. Together with the Chief Executive of Public Health Wales, I attended several meetings with the acting Chief Executive and Executive Nurse at Betsi Cadwaladr University Health Board (BCUHB). One meeting included the First Minister and the Health and Social Services Minister. Several of these meetings were attended by an official from CMO Wales' office. In these meetings I, and other representatives from Public Health Wales, provided advice to Welsh Government as well as the health board.

106. The Wrexham Maelor Hospital outbreak also coincided with a large community outbreak in Wrexham and the BCUHB public health team required considerable support from local health protection and microbiology services to respond successfully to this outbreak. This outbreak also attracted some political and media attention and I was involved in several meetings in response.

107. Welsh Government oversight of all of these outbreaks occurred through the Outbreaks and Incidents Subgroup of the HPAG.

108. Local Prevention and Response Plans: Following the production of the National Health Protection Response Plan and the publication of the TTP strategy, I oversaw the development of operational plans for Public Health Wales. I also advised Welsh Government in May 2020 of the need for local health boards to produce their own operational plans. These came to be known as Local COVID-19 Prevention and Response Plans. A request for these plans was made by the CMO Wales to the health boards and I worked with Public Health Wales colleagues to produce guidance for the development of these plans.

109. Following a letter from Welsh Government dated 27 July 2020, and publication of the guidance on 29 July 2020 [**Exhibit QS/26 INQ000147255**], health boards were asked to submit local plans to Public Health Wales "for their comment" by 12 August 2020. All plans had been received by 21 August 2020. Together with my deputy I personally reviewed all the plans and concluded that they did not provide assurance of a whole of Wales systems' response for the next phase of the pandemic. At the HPAG meeting on 24 August 2020 my deputy reported our findings and conclusions and recommended that, in addition to further development of the plans, there was a need to conduct local exercises to test the plans. HPAG resolved that Welsh Government would write to health boards in response to the plans.

110. By now Welsh Government had published the national Coronavirus Control Plan and the position, as I understood, was that the national Control Plan, together with the updated Communicable Disease Outbreak Plan for Wales and the Local Prevention and Response Plans, would set the planning context as Wales looked ahead to an expected increase in cases in the autumn.

111. I was therefore surprised to read in a letter, dated 21 September 2020, to the NHS and local authorities in Wales that I was copied into, from the Chief Medical Officer for Wales, the Director General Health and Social Services and the Director of Local

Government, subject heading Local Containment Plans: Welsh Government Feedback, stating that: "*Events have moved on rapidly since then. We had anticipated providing further feedback from the Welsh Government policy departments, however it has not been possible to finalise that. Given that the plans are now likely to be considerably further developed, providing feedback on the original versions is unlikely to offer significant additional value. As such, we will not be providing formal feedback on your local plans. We are sorry for any inconvenience this might have caused*" [**Exhibit QS/27 INQ000147256**].

112. I believed then that the health boards had been let off the hook and the opportunity to prepare Wales for the expected increase in case numbers as we approached the autumn had not been fully realised. In comparison, I had led a process that had led to the development of a Stage 1 Plan for Public Health Wales for Test Trace Protect (TTP), which focused on rapid implementation between 4 May 2020 (the date Public Health Wales submitted the National Health Protection Response Plan to Welsh Government) and 8 June 2020 (the date of the formal launch of TTP), and a Stage 2 Plan that commenced mid-June 2020 and carried Public Health Wales through to late October 2020, when Public Health Wales published its new operational plan to take the organisation through to the end of the 2020-21 financial year.

113. Increasing case numbers late August/ September/early October and introduction of local/regional restrictions: During this period, in response to clusters of COVID-19, incident management teams were set up in several local authorities in Wales and I was involved in discussions with local authorities and Welsh Government (officials and elected members) about implementing local restrictions.

114. In early September 2020 I wrote to the Chair of the COVID-19 Planning and Response Group (previously referred to as the H&SSG Coronavirus Planning & Response Group) setting out my concerns at the changing epidemiological situation in Wales, with case numbers rising and the occurrence of local outbreaks. I referred to my assessment in August, provided to the CMO, of the Local Prevention and Response Plans submitted by health boards, when I said that health boards, working with local authorities, needed to strengthen their plans to match the scale and speed of response we could anticipate. I also acknowledged the extant planning guidance published by Welsh Government on 24 June 2020. In concluding, I recommended the "*NHS in Wales plans now for the possibility of an early increase in transmission…and… that further efforts are made to improve (the) effectiveness of TTP by improving case ascertainment, reporting, and response by and to individual*

cases". In reply, the Chair expressed the view that "*the planning assumptions still stand…(and)are designed to provide sufficient cover and contingency in the system in readiness for any future covid demand*".

115. In a paper I prepared at the request of the Chair of the TTP Programme Board in mid-October 2020, I drew attention to the current epidemiological situation (case numbers increased substantially over several weeks with most local authorities subject to local restrictions) and the pressure this was having on the Public Health Wales workforce [**Exhibit QS/28 INQ000147257**]. I suggested the need for a "*system discussion…to ensure an appropriate and sustainable specialist health protection input*". I also recommended "*a review of the reporting and escalating requirements set out by Welsh Government*", which had become very burdensome for Public Health Wales. I concluded by giving notice of my intent to submit a business case for further investment in health protection resources. Welsh Government responded by agreeing to modify the reporting and escalating requirements and a business case was submitted to Welsh Government by Public Health Wales in November 2020.

116. Reintroduction of national restrictions: Over the weekend of 10 and 11 October, Incident and Strategic Directors at Public Health Wales met with Welsh Government officials to discuss options for the next stage in the response to the pandemic. On 12 October 2020 the same people met with CMO Wales and offered to provide an advisory note, which I co-authored the same day with the Professional Lead Consultant for Health Protection [**Exhibit QS/29 INQ000147258**]. Our advice then was for Welsh Government to implement restrictions (what came to be referred to as a 'firebreak') "*sooner rather than later*" (we suggested within the next two weeks) and "*for long enough*" (we suggested at least three weeks). We also restated the need to enhance TTP. In doing so we acknowledged the difficulty presenting this to the public and the need to simplify guidance informed by behavioural insights.

117. A 'firebreak' was implemented in Wales between 23 October 2020 and 9 November 2020. During this period, and at the request of Welsh Government, Public Health Wales submitted another advisory note to CMO Wales, dated 24 October 2020, of which I was a contributory author, to inform Welsh Government decisions about the steps to be taken following the 'firebreak' [**Exhibit QS/30 INQ000147260**]. In this note we concluded that "*the next framework for response needs to balance a regulatory approach with an approach that seeks to enable our population to adopt and maintain the right behaviours with access to simple messaging and knowledge*

to help them make informed, risk-based decisions". This did not exclude the possible need for "*further short, sharp (more restrictive) circuit/fire break interventions to suppress and control the virus at a local or national level*".

118. The advisory note emphasised the need to "*reduce any regulations to a minimum and replace…with advice to the public on behaviours that will reduce transmission. This will allow the public to decide the importance of the behaviours they will adopt versus the risk they represent*". The advisory note acknowledged the harms from restrictions (on personal mental health, access to health care, and on employment) and restated the importance of key non-pharmaceutical interventions including working from home, social distancing, and self-isolation if symptomatic or for returning overseas travellers. It also recommended Government financial support to individuals and businesses to support required responses and behaviours. It concluded by recommending (a) "*review of the current 'thresholds' to include further segmentation/risk stratification*".

119. Effectiveness of local and regional restrictions and the 'firebreak': Although I supported the introduction of local and regional restrictions in response to the epidemiological situation in a particular geography at a particular time, and I hoped that, together with behavioural management approaches, the need for national restrictions could be avoided, it was clear to me by mid-October 2020 that this approach was no longer sufficient to control the spread of COVID-19. After the 'firebreak' introduced in October 2020, Public Health Wales prepared a ministerial briefing dated 16 November 2020, which reported that the 'firebreak' seemed to have halted the exponential growth in case numbers but that the gain was unlikely to be sustained, and we would "*find ourselves in a pattern of serial short firebreaks in between a more behaviourally focused approach to enabling people to live with COVID-19 pending an effective vaccine and programme* (roll-out)" [**Exhibit QS/31 INQ000147261**].

Other specific points

120. Public health communications/behavioural management: With reference to my role in public communications this was limited to comment on, or approval of, daily statements and some press releases provided by Public Health Wales. I did not take part in any public meetings or give interviews to media organisations. Instead Public Health Wales identified a limited number of named spokespersons in accordance with established practice in emergency response.

121. More generally, the majority of the public health communications I had involvement with were produced to support Welsh Government as the primary source of communications to the public. This included some guidance documents, briefings and advice notes. I also undertook occasional technical and professional communications to other stakeholders e.g. health boards, local government and multi-agency strategic partners.

122. Specifically on behavioural management, I attended a webinar in July 2020 (see paragraph 140) and passed on information to our behavioural insights team. Otherwise I had no involvement in developing public health communications on this intervention.

123. Welsh Government communications: In the period that I was Lead Strategic Director, the Welsh Government's public health communications during COVID-19 that I thought worked well included the announcement by CMO Wales of the first and initial deaths from COVID-19. At a time of significant public concern, this allowed the most senior medical professional in Wales to reinforce public health messaging. Related to this I thought the Welsh Government website was useful as a source of public information. I also thought the Welsh Government press releases were helpful.

124. Two areas that presented challenges were, first, translation of advice and changes in case definition originating from PHE into Welsh, which was resolved through a simple process agreement, and, second, a request, at one stage, from Welsh Government for joint badging of guidance. Public Health Wales resisted this as it would have created confusion about the distinction between our respective organisational roles.

125. WhatsApp groups and private communications with Welsh Government: I was not part of any WhatsApp groups or had any private communications with Welsh Ministers or senior Civil Servants about key decisions.

126. Communications between Welsh Government and UK Government, in particular regarding Wales:England border: I was not party to communications between the Welsh Government and the UK Government about local and regional restrictions in Wales, and therefore unable to provide an informed opinion on whether any communications, or cooperation, between the two governments had an effect on the application of these restrictions in Wales. In a general sense, insofar as it was raised

in discussions at meetings I attended, I was aware that there were issues for those living on the border between England and Wales arising from different policies between the two countries. However, I was not involved in specific discussions with Welsh Government or between the Welsh and UK Government on how to address these issues.

127. Matters associated with the Welsh/English border that I did discuss within Public Health Wales and with Welsh Government through the TTP Oversight Group included access to laboratory test results from English laboratories. The establishment of NHS Test and Trace in England in June 2020 and the processes agreed between Public Health Wales and Test and Trace for data and broader intelligence sharing helped to address this issue.

128. International travel: The World Health Organisation is cautious about the use of restrictions on international travel and decisions on these matters fall outside the competence of the Welsh Government. I was aware that several European countries did apply restrictions on travel between countries early in the course of the pandemic. However, enforcing these restrictions is not straightforward and I think the approach taken in the UK during the early stages of the pandemic – to advise against all but essential travel to specified countries and to ask people to self-isolate on their return to the UK – made sense. A few months later international travel was covered by regulations and paragraphs 98-101 refers to my involvement in the implementation of border controls in Wales.

129. Non-pharmaceutical interventions: My involvement in the provision of information, data, analysis or advice concerning decisions about these non-pharmaceutical interventions was limited to occasional receipt of guidance for comment, advice to the NHS on the interpretation of specific guidance during discussions, for example, at the H&SSG Coronavirus Planning & Response Group, and discussions about their use in the context of other discussions about restrictions, for example, during discussions about local, regional and national restrictions between September and October 2020.

130. I was not involved in any discussions with Welsh Government about the impact of non-pharmaceutical interventions on 'at risk' and other vulnerable groups. Professional leadership on non-pharmaceutical interventions at Public Health Wales was provided mainly by the infection prevention and control medical and nursing leads and I would expect that any discussions on this matter would have been with

these leads. As stated in the Public Health Wales Corporate Statement for Module 2B, advisory notes were produced by Public Health Wales on several of the listed non-pharmaceutical interventions but this was after I had retired.

131. Specific events in Wales March 2020: In the next three paragraphs I set out my personal recollection and understanding whether Public Health Wales was approached by Welsh Government for advice surrounding mass gatherings, with specific reference to three events that were scheduled to take place in March 2020.

132. Newport Dragons Rugby Football Club vs Benetton Treviso match: I have no recollection of being involved in any discussions about this event, nor I can find, following searches of my personal records, evidence to show my involvement with any advice given by Public Health Wales to Welsh Government.

133. Six Nations' rugby match, Wales vs. Scotland: I have no recollection of being involved in any discussions about this event, nor I can find, following searches of my personal records, evidence to show my involvement with any advice given by Public Health Wales to Welsh Government, nor any decision taken by Welsh Government. I do recall learning after the match was cancelled that an informal discussion had taken place between the chief executive and one of the incident directors from Public Health Wales with the Minister for Health and Social Services late morning Friday 13 March 2020. It is my understanding that the Minister was advised to postpone or cancel the match.

134. Sterephonics concerts: I have no recollection of the concert(s) given by the Stereophonics and I can find no evidence to show my involvement with this event(s) following searches of my personal records. Three years later, I can see from online searching that a concert took place on Monday 16 March 2020. However, I have not found any evidence in my personal records that the Welsh Government approached Public Health Wales for advice on this event.

135. Applying learning from earlier stages of the response: I can only comment for the period to the end of November 2020. The National Health Protection Plan produced by Public Health Wales in April 2020 was informed by our learned experience of leading the response prior to the move from 'containment' to 'delay'. It was also further informed by our early learning from international experience, for example, following a meeting with the President of the Robert Koch Institute in Germany in April 2020 (see paragraph 141).

136. Lessons learned documents: In the period up to the end of November 2020, examples of lessons learned documents that I had involvement with were the National Health Protection Response Plan, and the debrief reports following Exercise Seren in early March and Exercise Barod in early August. The National Health Protection Response Plan, though not identified as a lessons learned document, was the product of applying lessons learned from the first phase of the pandemic. Exercise Seren identified issues in relation to the application of restrictions, which were mostly addressed by legislation. Exercise Barod assessed The Communicable Disease Outbreak Plan for Wales that had been updated and published in July 2020, acknowledging that the exercise and the Plan "*provided clarity on the roles and responsibilities of an OCT and how these groups can be expected to interact with Civil Contingency structures*" but requested "*further documented clarity on the role of an IMT* (incident management team) *in a communicable disease outbreak*". I understand all of these documents have been produced with the PHW Corporate Witness Statement for Modules 1 and 2B.

137. IANPHI and learning from international experience: IANPHI (International Association of National Public Health Institutes) is a voluntary membership organisation that was founded in 2006 and at the end of 2022 had 115 members (recognised national institutes of public health) in 98 countries. IANPHI's mission is to "collectively build(s) public health capacity and capabilities by connecting, developing and strengthening national public health institutes worldwide". Public Health Wales joined IANPHI as an Associate Member in 2012 and, following an application process, was elected as a full Institutional Member in 2016. Through its membership of IANPHI, Public Health Wales has access to insights and experiences of almost half the countries in the world.

138. In 2019 IANPHI established four regional networks, Asia, Africa, Europe and Latin America, modelled on an arrangement that had been in place in Africa for several years. These Regional Networks mapped to WHO Regions across the world. As the Executive Director of Public Health Services at Public Health Wales, I was elected as the first Chair of the European Regional Network.

139. I convened an online meeting of European Directors of National Public Health Institutes on 11 March 2020, where it was agreed to organise further short webinars that became known as the IANPHI COVID-19 Webinar Series. In the first eight months of the pandemic, before I retired, IANPHI delivered seven webinars; I attended five of these.

140. The first webinar of the IANPHI COVID-19 Series was held on 24 March 2020 and featured the President of Italy's Istituto Superiore di Sanita describing the response to COVID-19 in the first month of the pandemic. Other webinars I attended included a report from the Korea Centers for Disease Control and Prevention on 7 April 2020; a webinar on lockdown de-escalation strategies in Europe on 15 May 2020, which informed discussions in Public Health Wales about the metrics for monitoring the lifting of restrictions in Wales; modelling future trends on 3 June 2020, a summary of which I shared with epidemiologists in Public Health Wales; and a webinar on the mobilisation of behavioural science, held 10 July 2020, which led to contacts between members of the behavioural science unit in Public Health Wales and RIVM (the national public health institute) in the Netherlands.

141. In addition, I arranged and took part in a meeting between the President of the Robert Koch Institute in Germany and the Chief Medical Officer for Wales. This was held on 18 April 2020 and coincided with discussions taking place in Wales on the next steps for the response to COVID-19.

142. All these webinars and meetings fed into meetings dealing with or impacting upon Welsh Government's response. For example, the webinar with South Korea and the bilateral discussion with the Robert Koch Institute in Germany, both in April 2020, revealed several insights into the structural preparedness and the requirements necessary for an effective early response. These included:

- Laboratory capacity for testing
- Human resources necessary for contact tracing
- Coordination of the response in the first phase

143. I referred to the experiences of both countries at the Senedd Health, Social Care and Sport Committee hearing into COVID-19 held on 7 May 2020.

144. Overall assessment of working with Welsh Government: In my opinion the question is not whether Public Health Wales was adequately involved, or involved early enough, but whether Welsh Government was sufficiently aware and involved in the response to COVID-19 at an earlier stage.

145. With the exception of the Office of the Chief Medical Officer for Wales, and CMO Wales in particular, evidence of Welsh Government involvement in the early stages of the pandemic was not clearly evident to me. I felt that Public Health Wales was

providing national leadership and co-ordination of the response to the new threat posed by the emergent infection in China from first awareness at the end of the first week of January 2020 until mid-February 2020. In my view this leadership and co-ordination should have come from Welsh Government at the outset. In attempting to fill this need, and as an example of the challenge this presented to Public Health Wales, I was acutely aware that we lacked the authority to direct the NHS in Wales, for example, to establish capacity and capability to support initial assessment and sampling of suspected cases.

146. As a demonstration of national leadership and co-ordination by Welsh Government, I thought that Welsh Government should have stood up the Emergency Co-ordination Centre (Wales) by the end of January 2020, and I personally thought that the conditions for invoking the Pan Wales Response Plan had been reached by the end of February 2020. **[EXHIBIT QS/32 INQ000089571]**

147. There were several reasons why I thought the ECC(W) should have stood up by the end of January 2020. First, it seemed evident to me that a public health emergency was already occurring in other countries and could occur in the UK. On 30 January 2020 the WHO declared that COVID-19 was a Public Health Emergency of International Concern. Second, Public Health Wales was already processing and disseminating in Wales a huge amount of information as part of a PHE-led UK response, and the demands on the organisation from this had contributed to the decision to activate the Public Health Wales Emergency Response Plan on 22 January, as described in paragraphs 25-27. A role of ECC(W) is to co-ordinate the gathering and disseminating of information. It seemed to me that this role in Wales was largely being led by Public Health Wales. Third, alongside Welsh Government, Public Health Wales was undertaking reporting to the UK level via the PHE-led IMT with the potential for miscommunications. In my view co-ordinating reports to the UK level is a role for Welsh Government and the Pan Wales Response Plan describes this as a role for the ECC(W). And finally, even though local civil contingency arrangements had not stood up, the Pan Wales Response Plan states that Welsh Government can use ECC(W) "unilaterally…to centralise its own response to any emergency". Whilst acknowledging that the conditions for an emergency in Wales had not been met, it was already clear by the end of January that the UK was dealing with an exceptional public health threat and therefore I thought there could be value in setting up an ECC(W).

148. In early March 2020 I was informed that ECC(W) had been stood up but I didn't recognise its functions in terms of the Pan Wales Response Plan. This would have included coordination between the UK and local and pan-Wales inputs to the response. Instead, in my experience, it was used as a central facility to assist Welsh Government respond to specific queries it had received. Given that all four strategic coordinating groups (SCGs) in Wales had either stood up, or were in the process of standing up, by early March 2020, ECC(W) could have been used as a means of coordinating a multi-agency response.

149. There were three reasons why I thought that the conditions for invoking the Pan Wales Response Plan had been reached by the end of February 2020. First, even though a pandemic had not been declared it seemed to me that this was very likely to occur and therefore the Civil Contingencies Group (CCG) ought to have been convened (a level 1 activation of the Plan). Although a H&SSG Coronavirus Planning and Response Group had been established (paragraph 79), this was limited to NHS Wales and social services and did not include wider civil resilience partners. Second, strategic coordinating groups were being set up and the CCG, as described in the Pan Wales Response Plan, would have been an appropriate forum for providing strategic leadership to this civil contingency response. Finally, following the first confirmed case of COVID-19 in Wales on 27 February 2020, confirmed case numbers rose rapidly and it quickly became clear that this was an emergency affecting the whole of Wales. At this point, under the Pan Wales Response Plan, the pan Wales response would have been escalated to level 2 and ECC(W) established, if not already, with the roles as set out in the Plan.

150. Over the next few months during the national lockdown and the immediate phase after, I thought Public Health Wales and Welsh Government worked well together, first developing the National Health Protection Response Plan, and then implementing the Welsh Government Test Trace Protect strategy. However, as our response and the planning to accompany this developed from March 2020, I do not recall being informed that the Pan Wales Response Plan had been activated, if that was the case. And although the Director of Local Government in Welsh Government (responsible for civil contingency) became more visibly involved in the response from June 2020 onwards, the governance structures Welsh Government put in place were unlike those set out in the Plan.

151. Later in the response, during the summer when case numbers had declined after the first wave, I thought Welsh Government should have taken a more assertive

stance with the health boards to produce more robust and tested prevention and response plans in preparation for the expected increase in case numbers as we approached the autumn. I was surprised therefore when, in late September, Welsh Government seemed to back away from these plans because "*events had moved rapidly since*" (the plans were first requested at the end of July).

152. In the last phase of my involvement in the response I commend Welsh Government for accepting our advice in October 2020 to introduce a 'firebreak' knowing that this was a contentious issue.

153. Final reflections: The key challenges faced by Public Health Wales, and the organisational response to these, are set out in the Corporate Witness Statement for Module 2B provided by the Chief Executive, Dr Tracey Cooper. The specific challenges I dealt with personally included mobilising staff to fulfil essential roles, initially in our call and contact centres, and later expanding the specialist health protection workforce. Before I retired at the end of November 2020, I had drafted a business case for expansion of the health protection service in Public Health Wales as part of a wider proposal for strengthening the health protection system in Wales.

154. Another challenge I was involved with was the setting up of the first mass sampling centre at Cardiff City Stadium. The rapid delivery of this service was largely due to the redeployment of a significant proportion of the breast screening staff employed by Public Health Wales, who established the centre modelled on the experience of running a population-based screening programme. This, in turn, was only possible because of the suspension of the cancer screening programmes. However, the suspension and the subsequent reactivation of the national screening programmes provided by Public Health Wales presented its own set of challenges. Phased reactivation commenced three months after the programmes were suspended in mid-March 2020 but the impacts from this short period of suspension were not resolved before I retired at the end of November 2020 and catch-up continued after I left.

155. There are two lessons I have learned personally from my experience in supporting core political and administrative decision-making and the Welsh Government's response to COVID-19. The first is the need for early action. I don't think Public Health Wales could have acted more quickly and the only internal constraint in the period January to March 2020 was our capacity to mobilise for the scale of the response required. However, with the exception of the Chief Medical Officer for

Wales, and his staff, I did not sense the same awareness of and urgency about the infectious disease threat in China across the rest of Welsh Government. What I think was missing in the first few weeks, from 8 January 2020 when I first became aware to 20 February 2020 when the H&SSG Coronavirus Planning & Response Group first met, was national strategic leadership and co-ordination from Welsh Government.

156. The second lesson for me personally follows from the first and that was the importance of being able to scale up (the response) quickly. This includes early local public health and clinical assessment and implementation of sampling capacity, as well as contact tracing and testing. We were fortunate in Wales that the first confirmed case occurred at the end of February 2020 as this gave us a few more weeks to put in place necessary elements of the response across the NHS and to relieve some of the pressure on a handful of specialist staff in Public Health Wales. It was not lost on me that Public Health Wales had provided refresher training for health staff in using personal protective equipment in order to respond to high consequence infections only a few months before COVID-19.

157. Rapid scaling up requires a system response under national leadership, with authority to direct, supported by access to a reserve workforce, including volunteers, that can be mobilized quickly. Test Trace Protect eventually provided the minimum response necessary but was only established four months after the global emergency was evident. On this point, I feel strongly that the lessons learned from our experience are not forgotten and this should include retaining a volunteer (public) reserve workforce that can be mobilized across Wales, managed locally, supported by specialists from Public Health Wales, and coordinated and led strategically by the Welsh Government that is able to respond to any future infectious disease (and other public health) threat.

158. Finally, to end on a positive note, and insofar as it might not be recognised otherwise, I want to place on record the role played by Public Health Wales and Cardiff University in the use of pathogen genomics to support the response to COVID-19. For several years before the pandemic I, and others, had argued for Welsh Government investment in genomics as a clinical and public health good. In 2017 Welsh Government provided funding for sequencers in Public Health Wales laboratories. In 2018 Public Health Wales established the Pathogen Genomics Unit (PenGU) as part of its microbiology division. In 2020 this investment paid off.

159. By the time I retired Wales had sequenced about 15% of all positive Welsh cases, representing almost 25,000 SARS-CoV-2 genomes. This was the highest proportion of all the UK nations. A small team of scientists and clinicians used this data to inform the public health response in Wales, for example, in outbreak identification and management, as well as Welsh Government and NHS decision-making. And to-date, I am informed, COVID-19 sequencing in Wales is ranked one of the most effective in the world, in terms of the absolute numbers of genomes sequenced and the proportion of cases sequenced.

Statement of Truth

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

Signed:

Personal Data

Print name: Dr Quentin Sandifer OBE

Dated: 4 September 2023