Witness Statement of: Dr. Gillian Richardson
No. of Statement: 1
Exhibits:12
Date of Statement: 21 September 2023

UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF GILLIAN RICHARDSON

I, GILLIAN RICHARDSON, WILL SAY AS FOLLOWS:

1. I provide this statement in response to a request made by the Chair of the UK Covid-19 Public Inquiry ("the Inquiry") under Rule 9 of the Inquiry Rules 2006 dated 2 February 2023 and referenced M2B-WG-GR-01.

Preface

2. The purpose of this statement is to assist the Inquiry in its understanding of the way in which individuals worked and made decisions during the Covid-19 pandemic within or with the Welsh Government. This is in relation to the scope of Module 2B which considers core political and administrative decision-making as well as how and why key decisions were taken on the use of NPIs in response to the Covid-19 pandemic.

3. As I am not longer working for the Welsh Government, I have received support from the Welsh Government's Covid-19 Inquiry Team accessing and collating information to enable me to provide this statement and the exhibits to this statement.

4. The information in this statement and the material exhibited is not intended to provide a complete picture, rather this is produced to illustrate key aspects of the Welsh Government's response to Covid-19 of which I had specific personal experience and knowledge.

Background and qualifications and experience

5. I qualified as a medical doctor in 1985 in Wales gaining Bachelor of Medicine, Bachelor of Surgery (MBChB) and then pursued training in General Practice, becoming a Member of the Royal College of General Practitioners, London ("MRCGP"). I initially worked and lectured in General Practice and Community Child Health. As part of my vocational training, I spent a six-month field work placement overseas leading on the evaluation of mass vaccination campaigns for children in Morocco, for UNICEF and the World Health Organisation.

6. Following my return to the UK I trained in Public Health Medicine, gaining a Masters ("MPH") and then qualifying as a Consultant in 2002, first gaining Membership then Fellowship of the Faculty of Public Health UK (London) ("FFPH") and Membership of the Royal College of Physicians, Ireland (Public Health Medicine) ("MRCPI"). I initially worked in Child Public Health followed by General Public Health, including participating in the out of hours on call rota for Wales for communicable diseases, incidents and outbreaks. I continued to participate in this rota for the next 18 years, despite changes of post and employing organisation, and attended regular Emergency planning events, including influenza pandemic preparedness and Gold level emergency planning officer training.

7. In 2003 I became Local Public Health Director for Caerphilly Local Health Board (which is now part of Aneurin Bevan University Health Board) covering a population of close to 170,000 people, directing a small team ensuring that the health protection, health improvement and health care improvement needs of the population were met.

8. Following the reorganisation of the NHS in Wales in 2009, I became the Executive Director of Public Health for the Aneurin Bevan University Health Board in Gwent, covering a population of close to 600,000 individuals, and directing a larger team, but with the same aims as previously in Caerphilly.

9. During my time at Aneurin Bevan Health Board I sat on Gold command for the Celtic Manor NATO summit, for health, along with colleagues from the Health Board and Public Health Wales NHS Trust ("Public Health Wales"). I also led two 'look back' exercises, one for blood-borne viruses which was led from Wales but involved the other UK nations, and one look back, following an outbreak in a tattooing parlour, affecting mainly young people in Newport. I also led the Measles, Mumps and

Rubella catch up campaign for my Health Board, following outbreaks of measles across Wales, and implemented a childhood vaccination transformation programme.

In 2017 I moved to Public Health Wales as Assistant Director of Policy, Research and International Development. Public Health Wales organisational aims and work are outlined in Exhibit **GRM2B-01/01 - INQ000182586** and a list of my clinical publications is attached at exhibit **GRM2B-01/02 - INQ000182585,** covering the period 1987 to 2023.

10. Due to prolonged sickness absence of a Senior Civil Servant in the Office of the Chief Medical Officer for Wales ("CMO(W)") I began to support the Office of the CMO(W) for occasional days towards the end of October 2019, 'on loan', at that stage on a goodwill basis, from Public Health Wales. The role was Senior Professional Advisor to the CMO(W) and included general support on public health issues, maintaining effective relationships with Public Health Wales, and helping to coordinate the efforts of Welsh Directors of Public Health. By December 2019, this support was increased to 3-4 days per week to support delivery of key priorities and programmes for health improvement.

11. As a result of this arrangement, I supported the Welsh Government civil service colleagues and was present when the Covid-19 situation began in Wuhan, China. This arrangement initially helped with the close working required between Public Health Wales and the CMO(W) office until formal meeting structures were established.

12. I worked directly to the Chief Medical Officer of Wales initially 'on loan' and then on secondment to the Welsh Government from Public Health Wales, from April 2020. From the end of April 2021, I became Deputy Chief Medical Officer for Vaccines until the close of my secondment period at the end of June 2022.

Initial response to the pandemic – January to March 2020

13. In my official capacity within the Welsh Government, my first recollection of official communications around Covid-19 was towards the end of January 2020 when I was sent by the Welsh Government's Public Health team a copy of an alert issued by Chris Whitty, the Chief Medical Officer for England. This alert confirmed what we had been hearing through various colleagues and the media, that there had been reported cases in China of respiratory infections caused by a novel coronavirus. A public health link from the CMO(W) was prepared for Wales which adopted similar

lines. A copy of this is exhibited in **GRM2B-01/03 - INQ000048558.** In this letter the CMO(W) confirmed that if the novel coronavirus is detected the patient will be transferred to an airborne High Consequence Infectious Disease ("HCID") centre and Public Health England would undertake contact tracing and advise on management as more is known about this virus.

14. I was not involved in the work on or decisions relating to HCID bed capacity in Wales. I have been informed by those supporting me within the Welsh Government in responding to the Inquiry's request for evidence that before January 2020 there were no HCID beds in Wales and this did not change between January 2020 and May 2022. There are however arrangements in place for Welsh patients to be treated at HCID facilities in England if required.

15. In January 2020 as the Covid 19 pandemic spread throughout Europe and then to other UK nations Wales was fully expecting and prepared for our first case and Public Health Wales had worked on detailed plans agreed with the CMO(W) Office and Public Health England for dealing with this eventuality. As with other rare and novel infections with serious consequences, initially patients are managed by a single clinical team to maximise learning (In this case the Royal Free Hospital team).

16. I am aware that the CMO(W) issued a letter on 13 February 2020 requesting that all health boards confirm their ability to provide in-patient care for assessment and testing of possible cases of Covid-19 requiring hospital admission and to clarify steps being taken to address this, barriers to achieving it and timeline for delivering it. This included confirmation of compliance with a Welsh Health Circular issued in 2018 on Airborne Isolation Room Requirements which required each health board in Wales to have at least one Negative Pressure Suite ("NPS") able to accommodate a case requiring respiratory isolation in either an acute respiratory unit, or an infectious diseases unit or a medical unit with access to respiratory expertise. A copy of this letter is exhibited in **GRM2B-01/04- INQ000227377.**

17. On 27 February 2020 our first patient was admitted to hospital as a suspected case, with a history of becoming unwell and having recently returned from Italy (where transmission was known to be occurring) from a skiing trip. A confirmatory test showed the patient was Covid-19 positive. As a consequence they were transferred to a HCID bed at the Royal Free Hospital (because Covid-19 seemed able to affect previously healthy individuals and with high morbidity and mortality rates). The CMO(W) announced this on the 28 February 2020.

18. Between January 2020 and May 2022, I believe that the number of NPS beds in Wales was increased but I was not personally involved in this aspect. It is possible that this comprised part of Dr Marion Lyons or Dr Chris Jones' portfolio. I am aware of work in February 2020 by Cardiff and Vale University Health Board to assess the work required to convert existing positive-pressure ventilation lobby ("PPVL") rooms to NPS and to consider a more permanent arrangement for an HCID unit at the Health Board.

19. The Welsh Government's Covid-19 preparedness and response: framework for the health and social care system in Wales published on the 18 March 2020 set out that the initial cases in the UK were cared for in HCID settings irrespective of the criticality of the level of health care required based on their symptoms. As the number of confirmed cases increased the initial capacity in dedicated HCID units was surpassed. There were 10 commissioned airborne HCID beds across five adult and paediatric centres in the UK. Additional HCID beds for other pathogens were available but there was a need to also ensure we retained capacity to respond to other incidents. The Framework confirmed that up to a further 600 beds could be potentially created in other Infectious Disease centres commissioned by NHS England where services could meet the HCID service specification. A copy of this guidance is exhibited in **GRM2B-01/05- INQ000182426**.

20. On the 19 March 2020 the UK government announced that Covid-19 was no longer considered a HCID. I understand that this was a decision taken by the four nations HCID group. I was not a member of this group and cannot provide any further information on the decision.

21. This was the four nations procedure agreed by Public Health Wales and the CMO(W) office with Public Health England and the Department of Health and Social Care. Early in the pandemic, allowing learning and expertise in management to be gained by the specialist team by treating the patients diagnosed early in the pandemic. Following confirmation of the patient's positive Covid 19 status, contact tracing then began by Public Health Wales in line with nationally agreed public health protocols - including family members/household contacts. In the early stages of the pandemic there was limited testing available and this only at a few specialist centres. The aim was to stop transmission of the virus from any individual who was carrying it to another.

22. Before this case there had been four nation meetings of the Chief Medical Officers and the Health Ministers of all four nations were also in regular contact. I did not attend these meetings but the CMO(W) or others in his team attended meetings with UK Government and would provide updates or brief readouts from the meetings.

23. In the period January to March 2020 the Welsh Government's strategy was in line with the UK strategy as set out in the UK Covid-19 Action Plan (published 3 March 2020), namely to contain the virus and then when containment was no longer possible to delay its transmission throughout the population. The Covid 19 virus was completely new to humans, despite being from a family of coronaviruses that usually caused minor self-limiting illness, and so there was a need for joint- learning across the UK and Internationally.

24. I am not aware of and was not involved in any discussions at the Welsh Government where the concept of herd-immunity was considered by the Welsh Government as a strategy for responding to Covid-19 during this period. In my opinion a strategy of allowing the virus to spread through the population in order to reach 'herd immunity', was not appropriate as a strategy for a High Consequence Infectious Disease such as Covid-19 because of the extremely high case-fatality rate. A strategy to develop herd immunity is only a viable option where a virus has much milder effects, with negligible case fatality or long-term effects.

25. In my view the Welsh Government, devolved governments of Scotland and Northern Ireland and the UK Government worked closely on joint learning and decision-making during the early response period. The Welsh Government assumed a regular rhythm of meetings with Public Health Wales and also Welsh Government officials with Public Health England, the other five nations (Republic of Ireland joined) and the four UK CMOs to prepare for the threat of Covid-19 and to ensure that there was sufficient preparation and investment in health and social care facilities including ventilators, medicines and oxygen. The Welsh Government during this early period had daily check in meetings with Public Health Wales. These were usually attended by the CMO(W), and Marion Lyons and Chrishan Kamalan from the CMO(W) office.

26. I was not involved in provision of advice or decisions concerning the imposition of, easing of or exceptions to the non-pharmaceutical interventions (NPIs). It was the CMO who attended most groups with decision making responsibilities concerning the Welsh Government response to Covid 19. I am not aware what advice concerning mass gatherings was sought or given by Public Health Wales to the

Welsh Government in the period January to March 2020. I do recall being copied into emails as part of the CMO(W) public health team about the approach to major events in March 2020 but I understand that advice was provided by Dr Robert Orford, the Chief Scientific Advisor ("CSA") for health. The small CMO(W) team was handling issues on many fronts, and while I may have been copied into emails I was not involved in this aspect.

27. I was also not involved in the discussion or advice to Ministers on putting in place a national lockdown. In my opinion, when faced with the unprecedented threat to national health by a virus, new to humans, as yet, poorly understood, but with high case fatality, for which there was no obvious cure or vaccine, and which risked overwhelming health and social care services, there was little option but to follow the example of other nations and impose a national lockdown.

28. I was not involved in discussions around international travel restrictions in this period, but am aware that Wales has only one airport, which receives international flights from a small number of destinations. Many people from Wales travelling internationally routinely use English airports, and as there is no controlled border between England and Wales, any travel regulations applied only in Wales would have been likely to be ineffective in infectious disease control.

29. In terms of Wales being kept informed regarding discussions at SAGE, Dr Robert Orford, CSA for Health attended SAGE as our Wales representative from the 11 February 2020. Following this the Technical Advisory Group ("TAG") for Wales was established and met for the first time on 3 March 2020. The terms of reference of this group outline its function to ensure scientific and technical advice including that from SAGE, was developed and interpreted for Wales. This included Wales being able to pose questions to SAGE. The timings of the regular TAG meetings were designed to complement and feed into the timings of the UK SAGE meetings. A copy of the TAG terms of reference are exhibited at **GRM2B-01/06 - INQ000066059**.

30. Between January and March 2020, I believe that the four UK nations were closely aligned in their decision making due to the overwhelming and yet poorly understood, new to human virus and the serious threat this posed to the population. Ministers and officials met regularly and agreed to work together. This is based on my understanding of the agreed publication of the UK Coronavirus Action Plan and work being progressed at the time on the Coronavirus Bill. I was not involved in these workstreams by members of the CMO(W) office, Chrishan Kamalan and Neil

Surman, were. The 'whole UK' move from 'Containment phase' to the 'Delay phase' was led by UK Government and having had time to reflect, I am unsure as to whether containment could have been continued in areas of the UK where the virus was not spreading as rapidly as it was in some parts of central urban England at that time. I have in mind areas, such as in rural parts of England, and in Scotland, Wales and Northern Ireland. The day prior to the UK announcement of the move to Delay phase, Wales had recorded 19 cases of Covid 19, and had contact traced 109 people. Of these, 76 were contacts of the confirmed cases resident in Wales. The remaining individuals were under follow up due to returning from affected countries or cruises or from being a contact of a confirmed case outside Wales.

31. In addition to in-hours contact tracing for many communicable diseases in Public Health Wales, they also maintained a 24 hour a day, 365 day a year on call rota for health protection incidents, staffed by a wider pool of Consultants in Public Health from all Directorates and the Health Board Directors of Public Health and their teams across Wales, which could be called upon for contact tracing. These routine public health contact tracing 'peace-time' systems were initially enhanced with additional resource but were under severe strain across the whole of the UK, especially so in London and some other major cities in England. However, once England had decided to move to 'Delay phase', it would have only been possible to sustain containment in the devolved nations for a matter of weeks, should they have diverged. Also, divergence would have been difficult to explain to and maintain the trust of the public and could have been potentially confusing at this early stage of the national and global pandemic.

Role in key decision-making and advice provided to the Welsh Government

32. Based on the initial information that was emerging, it became clear in that initial period that the speed of virus transmission and high case fatality rate were unlike anything we had experienced in the past and far higher than influenza, which had been the predicted direction for the next most likely pandemic in the years leading up to 2019.

33. During this early stage of the pandemic period, January to March 2020, the CMO(W) was heavily engaged in Ministerial meetings, Four Nations meetings and calls and the UK CMOs meetings, as well as engagement with the public and giving interviews. Initially, I did not have a defined role at the Welsh Government during January to March 2020 but given my public health experience I would be called upon

to provide whatever support the CMO(W) and his team required. The Deputy Chief Medical Officer ("DCMO"), Dr. Chris Jones, was leading on NHS Health Care and Quality and had NHS Medical Director experience but not NHS Director of Public Health experience and was not trained in public health for this this type of public health emergency.

34. This resulted in me assisting various officials in the Welsh Government on an ad hoc basis and providing clinical and sector experience information and public health advice. I was also, along with other officials in the Public Health Division, routinely a copy recipient on emails on early workstreams or queries. I would assist with clinical or public health advice where appropriate.

35. During this early period of the pandemic I undertook or allocated the rapidly incoming work tasks from the rhythm of daily teleconferences, ensuring prioritisation, setting timescales and reviewing products before submission to CMO(W). I worked with Senior Medical Officers and Civil Servants in the CMO Office, namely Marion Lyons, Heather Payne, NR NR edacted and Chrishan Kamalan, as well as new fixed term appointees who I had recruited in support.

36. Marion Lyons, Heather Payne or I would attend the daily calls with the Department of Health and Social Care and the four nations Health Protection and Emergency planning staff, this included providing cover for calls on weekends. I would attend the calls between Public Health Wales and the CMO(W) office which took place daily in order to take actions and reach out into the Welsh Government providing information or seeking it. From March 2020 the Director General Health and Social Services, Andrew Goodall held regular calls with the Chief Executives of NHS Wales which either myself or Chris Jones, DCMO, would cover for the CMO(W) if needed.

37. Other duties included commissioning and vetting briefings, Public Health Links and press statements. Following four nations Ministerial or COBR (M) meetings, notes from CMO(W) to the Health Protection Division team were copied to me so I could help the team to prioritise, source help and provide advice to assist in addressing requests or progressing agreed actions.

38. As noted above the CMO(W) and his team liaised closely with Public Health Wales with regular senior executive meetings, discussing advice regarding the proposed management of the Covid 19 pandemic in Wales. I was not involved in preparing advice from Public Health Wales to the CMO(W) Office, as I was based in the

CMO(W) office by this time. I would, however, liaise with Public Health Wales Executive colleagues and Executive Directors of Public Health responsible for Health protection in Health Boards. I would also review the advice that Public Health Wales was providing to the CMO(W) office and, during this early period and in the absence of wider stakeholder input via the Technical Advisory Group or Cell that had yet to be established, 'sense check' the advice line with the Welsh Government policies and Ministerial priorities.

39. The timing of the pandemic was unfortunate in that the CMO(W) office was vulnerable to other pressures at that time. The Senior Medical Officer, while experienced in Health Protection was on a leave of absence. Additionally, the Senior Civil Servant at Deputy Director level had been on intermittent, frequent leave of absence and the Chief Environmental Health Officer (who acted as a liaison point with local authorities for the CMO(W) on communicable diseases) had recently retired and his post had not yet filled.

40. The above set of circumstances left a public health leadership vacuum and DCMO equivalent level support was required for Public Health. Knowing the scale of the task should a pandemic become evident, I offered to remain at the Welsh Government, and Public Health Wales agreed, to assist with the response that would be needed. So while I was not brought in to take up this particular role, given my background and experience, I was quickly placed into an additional Senior Medical Officer (SMO) equivalent level figure to help lead the change in CMO(W) Office from health protection to surge response.

41. An early action taken was to create a CMO Office function "Silver group" to involve those with professional lead areas/other roles in CMO(W) Office in supporting the health protection team (eg Chief Dental, Chief Pharmaceutical, Chief Ophthalmic Officers, SMO's, policy leads and new fixed term personnel). Prior to establishment of HSSG Planning and Response group, CMO held twice weekly meetings which I attended and Chaired in his absence if required with PHW, CMO (W) Office, HSS and Welsh Government Emergency planning officials initially. WAST asked if they could join, and then invitation was extended to Directors of Public Health and (via David Goulding) Emergency Planning leads from Health Boards. These meetings were a precursor to the subsequent Covid-19 Health and Social Services ("HSS") Planning and Response Group. Following HSSG establishment these meetings did not continue in that format but PHW meetings with CMO continued and the CMO Silver group for wider CMO Office continued for internal communications. This was

initially chaired by the CMO(W) but as demands on his time increased this passed to me and the CMO's attendance to this group dropped off around September 2020. The group however continued to meet throughout 2020 and more informally in 2021.

42. On the 5 March 2020, Andrew Goodall, Director General of Health and Social Services and Chief Executive NHS Wales wrote to the NHS organisations in Wales outlining the key roles of senior civil servants in the Welsh Government in the response to Covid-19. In this letter he confirmed that I would be providing dedicated clinical expertise in my role as Professional Advisor to the CMO(W). A copy of this letter is exhibited in **GRM2B-01/07 - INQ000182386.**

43. From April 2020 I was formally seconded from Public Health Wales to the Welsh Government for 4 days a week. As outlined above there was a gap in public health experience in the Office of the CMO(W) due to leave of absence and retirement, which, bearing in mind that the day-to-day work of Health Protection Division for all other communicable diseases continued (TB, Meningitis etc), placed the CMO(W) office under considerable pressure.

44. I assisted the CMO(W) in building up the small communicable disease 'peace-time' team to a larger more specialised team which could be organised to cope with the huge surge in demand, with appropriate expertise, including retired personnel such as:

    a. Dr Sara Hayes, a former Welsh Government Senior Medical Officer for communicable disease (retired),

    b. Dr Merion Evans, a former Regional Epidemiologist for Wales (retired), who had assisted with the SARS epidemic in Asia,

    c. Dr Behrooz Behbod, Consultant in Public Health and Senior Epidemiologist

    d. Chris Brereton, a former Welsh Government Chief Environmental Health Officer (retired),

    e. Cathy Weatherup, an individual with International Health Policy experience from Public Health Wales; and

    f. **Name Redacted** a former Welsh Government Nursing Officer for Infection Prevention Control in the Nursing Directorate and was working for a private company but returned part time in April 2020 to the Chief Nursing Officer Office.

45. Part of this reorganisation also included establishing and participating in an on call out of hours rota for CMO(W) Office, for evenings, weekends, bank holidays, with a civil servant and clinical lead for 24 hour cover for advice to the Welsh Government .and with the CMO(W), DCMO(W) and myself also available on a 1 night/weekend in 3 rotation.

46. I initially line managed the fixed term experts which were recruited and also three public health trainees who were on a placement with the Welsh Government as part of their final stage of training. This involved allocating tasks, identifying the most suited personnel to address issues, reviewing products and preparing briefings so the CMO(W) could consider almost final versions of documents.

47. Between February 2020 and June 2022, I also assisted Samia Edmonds with the HSS Planning and Response Group which she chaired. We received regular updates from Technical Advisory colleagues including the CSA for Health and his team and Public Health Wales.

48. Officially I 'co-chaired' the HSS Planning and response group, but in practice it was Samia Edmonds in the Chair, except for leave cover when it was myself. I attended most meetings of the HSSG Planning and Response Group and provided verbal updates on progress of the response and later, once I had taken on defined responsibilities for vaccines, I updated on the vaccination programme. The remit of the group was to provide strategic coordination of health and social services contingency arrangements for Covid19. It had no role in decision making on national policy responses using NPIs, but members were able to share experiences, concerns and best practice on implementation of policy decisions made by UK or the Welsh Ministers. I was not a member of the Covid-19 Planning and Response Cell. The terms of reference for the HSSG Planning and Response Group are exhibited in **GRMB2-01/08 - INQ000066198**. A chronology of the meetings for the group as prepared by the Welsh Government Covid-19 Inquiry Team is also provided at **GRM2B-01/09 - INQ000101246**.

49. I also attended the CMO's Health Protection Advisory Group ("HPAG"), a chronology of the HPAG meetings as prepared by the Welsh Government Covid-19 Inquiry Team is exhibited at **GRM2B-01/10 - INQ000101243**. I was involved as well in the Public Health Senior Leadership meetings with Public Health Wales Executive team and the Directors of Public Health. Briefings submitted to these meetings would have

been in the main verbal and particularly after 2021 in the main updates on plans for, launch of and progress of the Covid 19 Vaccination programme.

50. I was an early member of the Covid-19 TAG Subgroup on Economic Harms, attending it's second, third and fourth meetings on 29 September 2020, 19 October 2020 and 4 November 2020. However, at this stage we were preparing in earnest for a possible December 2020 launch of the first Covid 19 Vaccine, and I was unable to continue with attendance.

51. I also attended the Covid 19 TAG subgroup on Risk Communication and Behavioural Insights as Deputy Chief Medical Officer for Vaccines, for 9 meetings starting from 1 September 2021 to 11 May 2022, to give verbal updates on the progress of the Covid 19 Vaccination Programme and to share with the group the challenges we were facing in the run up to the first Covid 19 Autumn booster campaign, with overcoming public fatigue with vaccine messaging, growing vaccine hesitancy and conspiracy theories.

52. I was not a member the First Minister's Black, Asian and Minority Ethnic Covid-19 Advisory Group.

53. I also led the Wales Convalescent Plasma Board at the request of the Welsh Government Civil Servant lead for the Wales Blood Transfusion Service, exploring whether in the period of absence of other treatments or vaccination this may be of benefit.

54. For most of the pandemic period my main role in the preparation and provision of advice was to provide input into any key decisions taken by the Welsh Government in relation to the Covid 19 Vaccination programme. As this will be the focus of a separate UK Covid 19 Inquiry module, I hope that the Inquiry will accept me detailing my role this area fully in that future dedicated module.

55. To briefly summarise my role, in June of 2020 it became necessary for a CMO(W) office clinical member to begin to get involved in the early 4 nation work on vaccines for Covid 19. Around this time as well, Marion Lyons, the Senior Medical Officer who had been on a leave of absence, had returned and the CMO(W) had his dedicated advisor on infectious diseases back in post. I therefore assumed a more specialist role from this point and began to attend four nation planning meetings and to build the team which would address this function from within the Welsh Government and from the NHS organisations in Wales. As such my role of assisting the CMO(W)

with obtaining and interpreting advice from professional advisors within his office transferred to the Vaccination function.

56. From June 2020 I led the Vaccination function assisted by many colleagues, including the Chief Pharmaceutical Officer and his team, until the primary campaign was delivered. We were joined by military planners for 7 weeks in the run up to the introduction of the first and second vaccines approved for use being launched in Wales. Support was also provided by a newly deployed Chief Operating Officer (Jeremy Griffiths) from early January 2021 and a Senior Civil Servant (Claire Rowlands) from late January/February 2021. In April 2021 the CMO(W) asked me to formally assume the role of Deputy Chief Medical Officer ("DCMO") (Vaccines) to support the increasing need for clinical expert leadership and four nation collaboration on the Covid 19 Vaccination Programme. The Senior Responsible Officer role for the Wales Covid 19 Vaccination Programme was then transferred to our programme Senior Civil Servant from 26 April 2021.

Experience of the Welsh Government working with others

57. During my time in the Welsh Government, I felt that information sharing and communication worked well between officials from the four nations of the UK in the main, although there were instances beyond their control which meant that decisions by UK Ministers were communicated later than would have been ideal on occasions. However, it is acknowledged that the entire system was under intense pressure with 'firefighting' actions regarding the pandemic in the early stages.

58. In terms of joint working on the Vaccination programme, I felt this was always strong amongst officials including with the UK Government Department for Business, Energy and Industrial Strategy, the Department of Health and Social Care and with my peers across the four nations responsible for Covid19 Vaccination. Ministerial joint working was also extremely close on the national Vaccination programme effort, especially before the change of UK Vaccine Minister (from Minister Zahawi to Minister Thrupe). Following this change, one to one video calls with devolved government Health Ministers and officials which had started, ceased.

59. In my opinion the Welsh Government involved Public Health Wales from the outset of the Covid-19 response and continually throughout the pandemic. The CMO(W) requested briefings and would then consider advice, consulting with CMO(W) office team members and the Chief Scientific Officer for Health and team, formulating

opinion and then advising Ministers. The Welsh Government would usually follow the advice from Public Health Wales. On occasions there may have adherence to the principles of the advice given by Public Health Wales but different implementation decisions in the interest of enhanced effectiveness. Although not personally involved in the community testing programme, I was aware that Public Health Wales had submitted a business case, but senior officials in the HSS Group were not confident that Public Health Wales would be able to build up laboratory testing capacity sufficiently rapidly, whilst simultaneously responding to the communicable disease control and surveillance needs of Wales and so decisions were made to meet the need through different methods, such as closer working with the Lighthouse laboratories being set up in England.

60. In respect of international intelligence and advice, the Welsh Government TAG structure included a subgroup on International Health Intelligence which informed lessons from the international response to Covid19 and the WHO collaborating centre at Public Health Wales also produced regular briefings.

61. In addition, regular international learning meetings and WHO webinars were attended by professionals in the CMO(W) team. These included joint online meetings with the United States Communicable Disease Surveillance Centre, Atlanta, the UK, including representatives from devolved nations and Israel. I also attended online meetings with epidemiologists from Italy, where the pandemic had hit earlier, and CMO(W) attended online educational meetings with Spain and Sweden.

62. In my role as Chair of the Wales Convalescent Plasma Board, exploring whether this potential treatment was effective, we linked to the Mayo Institute, United States as well as the other UK nations.

Consideration of vulnerable groups and harms from Covid-19

63. In terms of consideration of the effect of NPIs on 'at risk' or vulnerable groups, as outlined above, I was not involved in NPI policy advice, however I am aware that balancing the five harms from Covid 19, as detailed below, was difficult and that actions which would help mitigate one harm always had the potential to exacerbate another. For example, harms alleviated by preventing Covid 19 infections and pressures on health and care services, created other harms such as isolation and mental health effects during lockdowns.

64. The five harms identified were:

i. Harm directly arising from SARS-CoV2 infections

ii. Indirect COVID-19 harms due to surge pressures on the health and social care system and changes to healthcare activity, such as cancellation or postponement of elective surgeries and other non-urgent treatments (e.g. harm from cessation of screening services) and delayed management of long-term conditions

iii. Harms arising from population-based health protection measures (e.g. lockdown) such as, educational harm, psychological harm and isolation from shielding and other measures

iv. Economic harms such as unemployment and reduced business income arising both from COVID-19 directly and population control measures, like lockdown

v. Harms arising from the way COVID-19 has exacerbated existing, or introduced new, inequalities in our society

65. Technical Advisory Group considered establishment of baseline measures in order to measure the effects of actions on the five harms and released a report.

66. In recognition of the effects of the isolation of lockdown and subsequently shielding on the wellbeing of older people in Wales, I assisted in designing a programme with Age Concern Cymru and Welsh Government officials from HSSG and submitted a Ministerial Advice note which led to a decision to support the 'Friend in Need' Programme of telephone befriending and practical support. I chaired the Friend in Need Project Board that oversaw the programme. I also worked with Public Health Wales, the voluntary sector and Welsh Government officials to design bespoke communications for asylum seekers and refugees on how to access help during lockdowns.

67. Vaccination Equity was an extremely important consideration of the Covid 19 Vaccination Programme and a dedicated epidemiological surveillance programme was designed to track inequities in vaccine take up, with actions at Health Board and national level to address. A Vaccination Equity Committee with representation from the voluntary sector working with vulnerable groups was established, Chaired initially by myself, then by an Executive Director of Public Health for one of our Wales Health Boards. I also led on production of a Welsh Government Vaccination Equity Strategy.

The Vaccination Equity Strategy and Vaccination Equity Committee terms of reference and membership are provided in exhibits **GRM2B-01/11 - INQ000182538** and **GRM2B-01/12 - INQ000182550.**

Divergence and public communication

68. I was not involved in providing advice or briefings in respect of NPIs including the "firebreak" lockdown. I do not feel I can therefore comment on timings, but in my personal view, as the pandemic progressed, and the actions that would reduce transmission became better understood, and the rates of community transmission varied in ebbs and flows across the UK, divergence between the UK and devolved governments became inevitable and desirable in order to ensure the efficiency of response. If levels of community transmission were higher in one nation than another, over a period of time, this would lead to local strain on NHS services and so, in the absence of UK national actions, local actions by devolved governments in the interest of their populations and essential services, allowed finer tuning and calibration of response, including escalation and de-escalation. Based on my understanding, this was not possible for regions in England.

69. The pandemic was not uniform and was not experienced in a uniform way across the nations of the UK. Northern Ireland for example shared no land boundaries and so community transmission issues between their citizens and those of Ireland were more pertinent to decide appropriate response.

70. My main involvement with public health communications was concerning the Covid-19 Vaccination programme in Wales. I did on occasion assist the CMO(W) in the preparation of public health links, for example by reviewing or collating inputs from colleagues within the enhanced CMO(W) team staff, Senior Medical Officers and the professional advisors, but the CMO(W) would sign off the final version. Later, in my role as DCMO(W) (Vaccination) I issued three public health links all of which related to vaccination. The Communications teams in the Welsh Government and Public Health Wales worked closely and collaboratively, with wide consultation on all campaigns and materials, involving scientists and clinicians including myself. They also commissioned behavioural insight work to understand barriers to adopting protective behaviours, and for vaccination aspects, the Welsh Government and Public Health Wales convened meetings with ethnic minority populations and seldom heard groups to ensure materials were sensitively designed and culturally appropriate, with an understanding of fears and concerns of these communities.

71. Communication when control measures were in flux or where there was divergence between nations, especially in border areas, did present challenges, particularly I felt around how many people were allowed to meet in homes together or out socially and the nature of 'bubbles' permitted. The NHS Covid-19 app could possibly have been used to greater effect, to help with updated information depending on which nation one resided in. This app was commissioned by central UK Government, and I am unsure as to methods used for eliciting feedback by users in Wales or Welsh Government.

72. I had no role in advising on legislation or coronavirus regulations. As with other workstreams I was occasionally copied into emails, particularly in the early period of the pandemic, but in terms of the Public Health Division, it was my understanding that Neil Surman was leading on legislation such as the Coronavirus Act. The CMO(W)s office would be asked to provide advice on the public health situation for the Covid-19 Restriction Regulations and the International Travel Regulations, but I was not involved in this work or in the production of the advice.

Lessons learned

73. In terms of lessons learned I think that communications with the public were continually reviewed and improved. A national weekly online survey run by Public Health Wales throughout the pandemic – 'How are you doing?' helped give insights into the matters of main concern and message fatigue.

74. There are lessons around a united UK approach and the extent to which regions in England may have been given similar flexibilities to those able to be implemented by devolved nations, to enable a more reactive regional approach.

75. In the latter stages of the pandemic, I was involved in some meetings with UK Government officials in my role to advise the Welsh Government Senior Civil Service on the vaccination aspects of international travel regulations. For the reversal of international travel regulations, it felt to me, that the Department of Health and Social Care perspective became secondary to other Cabinet department concerns, and that there was a pressure by others to release restrictions early from some countries where there was low confidence in our understanding of the epidemiological picture. Because by this stage the Omicron strain of Covid 19 was dominant in most areas of the world, imported infections undoubtedly resulted but as the case fatality with this strain would have been much lower than original Wuhan, the Alpha or Delta

strains circulating earlier in the pandemic, this seemed to be judged acceptable in these meetings. For any more virulent strains with higher case fatality this arrangement would have not served us well in my opinion. For future pandemics, it is important that the voice representing Health has pre-eminence in my opinion.

76. Equality considerations beyond impact assessments, such as rapid consultation with third sector umbrella organisations representing vulnerable groups regarding the introduction of control measures would be a key learning point for me, to ensure plans for mitigation of possible increased adverse effects for certain populations groups. I am unsure if the implications of the initial UK lockdown on rates of domestic violence reporting or calls to Childline were monitored. These could have served as an alert to measure the effect of future controls also e.g. school closures.

77. In terms of CMO(W) office resourcing, there are lessons in ensuring sufficient staffing to allow for robust response to medical emergencies in future years, with sufficient critical mass to cover sickness and with resilient system, possibly including a retained bank of trusted and trained expert professionals who could be called on at short notice for rapid escalation needs.

78. I am not sure that sufficient notice to devolved nations on UK Government intentions was always given, but in emergency response adequate time for communication comes under pressure.

79. In terms of future research, I think understanding the cytokine response variation to viral infection, between individuals with different clinical conditions and different ethnicities is a key area that deserves increased focus, since it may explain a proportion of the variation that was seen in survival rates.

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.

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Signed: PD

Date: 21 September 2023