Witness Name: Professor Chris Jones
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR CHRISTOPHER JONES

I, Professor Christopher Jones will say as follows: -

Preface

1. The purpose of this statement is to assist the UK Covid-19 Public Inquiry (the Inquiry) to investigate key government decision making within the Welsh Government, the information relevant to such decisions and the role of senior officials and advisers.

2. My response to the Inquiry's request for evidence made under rule 9 of the Inquiry Rules 2006, referenced M2B/WG/CJ1/01, will cover the period from the 1 January 2020 and 30 May 2022 (which I will refer to in this statement as "the specified period").

A. Background and qualifications

3. I qualified as a doctor in London in 1981 and trained in cardiology and general medicine in London, Texas and Cardiff, before becoming a Consultant Physician and Cardiologist in Bridgend, South Wales, in 1994, and then Senior Lecturer in Cardiology in Cardiff University in 1999. I published extensively on integrated cardiovascular physiology in major international journals until moving into medical management and leadership. In 2009 I was appointed Medical Director of Cardiff and Vale University Health Board. In 2010 I was appointed Medical Director, NHS Wales and Deputy Chief Medical Officer (DCMO) for Health Services in Welsh

Government. I am honorary Professor in Cardiff University, appointed in 2016 and reappointed in 2021. I was appointed CBE for services to health care in the Kings Honours List in June 2023.

4. I initially became Deputy Chief Medical Officer in 2010 when I joined Welsh Government on secondment. I was formally appointed as DCMO for Wales through an open competitive process in 2012. Prior to the pandemic, Frank Atherton, as the incumbent Chief Medical Officer (the CMO), fulfilled the main leadership role for public health while I provided support mainly for his role as Medical Director, NHS Wales. This has meant that I differ from most other DCMOs in that I have held significant direct policy responsibility for a wide range of clinical service areas since 2010, many of which turned out to be directly relevant to the pandemic response. This includes the following areas:

    i. Healthcare quality policy
    ii. Patient Safety
    iii. Quality Improvement
    iv. Patient experience
    v. Blood policy
    vi. Healthcare acquired infections
    vii. Antimicrobial resistance
    viii. Critical Care
    ix. Respiratory Health
    x. Cardiac Health
    xi. Diabetes care
    xii. Cancer care
    xiii. Vascular Surgery
    xiv. Organ donation and transplantation
    xv. Renal medicine
    xvi. Liver Disease
    xvii. Neurological Conditions
    xviii. Stroke Care
    xix. End of life care
    xx. Frailty
    xxi. Patient consent

xxii. Medical Devices – safety / registration / information
xxiii. Medical device recording system
xxiv. Medical Examiners / Death Certification
xxv. Women's Health
xxvi. Children Health
xxvii. Neonatal care

B. Communication and Cooperation

5. Early in the pandemic, due to my policy responsibilities for areas such as critical care, respiratory, healthcare acquired infections and end of life care, my work was mainly focused on the NHS response to Covid-19, as opposed to the public health response.

6. I became gradually more involved later in 2020 as I was increasingly called upon to deputise for the CMO due to the increasing demands on his time and during his periods of leave, and also the increasing requests from within and outside Welsh Government for public health and clinical advice. By 2021, I was working across a very wide range of public health areas including education and local authority responses and communicating and cooperating with a number of individuals and groups which I will detail in this statement below. This is not an exhaustive list but a list of some of the key individuals or groups relevant to module 2B.

The First Minister

7. In the initial period of the pandemic during most of 2020 I did not have any need for regular contact with the First Minister in relation to the pandemic. As noted above public health and civil contingencies policy were not prominent within my portfolio of responsibilities as DCMO. The CMO led the public health response and therefore engaged closely with the First Minister in the initial few weeks and months, expecting me to lead on the NHS clinical response. My role changed gradually during the course of the pandemic as I was called on to deputise more for the CMO whose workload increased significantly and in light of the pandemic lasting longer and with wider impact than any of us initially thought. This meant, particularly in 2021 I became more involved. For example, the CMO had a regular Monday meeting with the First Minister, along with Robert Orford, the Chief

Scientific Adviser for Health (CSAH). I did not attend this in 2020 but started joining in 2021, as my public health role in the Covid-19 response increased.

The Minister for Health and Social Services

8. Prior to the pandemic I met frequently with the Minister for Health and Social Services (MHSS) given my portfolio of responsibilities. This would include providing updates or briefings to the MHSS on areas in my portfolio or accompanying the MHSS to meetings with key stakeholders. For example, on the 4 March 2020 I accompanied the MHSS as he attended the Academy of Medical Royal Colleges of Wales. The MHSS would also on occasion attend meetings with the Medical Directors Group or NHS Chief Executives and I may be asked to accompany him depending on the topic for discussion.

9. During the pandemic this remained the case but any meetings with the MHSS were always on a 'as required' basis depending on the issues for consideration at the time. I did not have a regular personal forum or meeting with the MHSS.

Welsh Ministers, Senior Civil Servants and special government advisers involved in the response to Covid-19.

10. Prior to the pandemic I was mainly focused on the HSSG and the MHSS areas of responsibility. As the pandemic progressed, I engaged more widely across the Welsh Government with officials and Ministers from non-health areas. This was partly as a result of my role in deputising for the CMO and also the cross-cutting nature of the Covid-19 pandemic. This was not just affecting health but all areas of life and therefore I would often be asked to support other Ministers, particularly in relation to engagement with stakeholders. For example, I was asked by Kirsty Williams, the Minister for Education, to provide public health briefings or information to the teacher's union and by Julie James, Minister for Housing and Local Government, to speak to local government stakeholders. This engagement with non-health ministerial portfolios represented the greater significance of the CMO and DCMO roles during the pandemic than previously and increased the demands on the office of the CMO as a result.

11. In addition to the above ad hoc interactions with other Ministers, I also attended Cabinet on a number of occasions, mainly when deputising for the CMO. A list of

Cabinet meetings attended by myself or other members of the CMO office is exhibited in **M2BCJ01/01-INQ000066201.** Examples of occasions where I provided written advice for the 21 day review of the Covid-19 Restrictions are exhibited in **M2BCJ01/02 – INQ000057847** and in **M2BCJ01/03 – INQ000057886**, where I agreed the general direction of travel being proposed by officials including the move to level zero in the Wales alert level system.

12. I would also have occasional ad hoc discussion with Special Advisors working with Ministers. This was most frequently with Clare Jenkins, the Special Advisor for the MHSS, but others may contact me to check information or to be signposted. This was informal and occasional usually occurring by Teams chat or calls and were unrecorded.

13. In terms of Senior Civil Servants again I was mainly focused on working with those within the HSSG, but this widened during the pandemic. I was primarily working with those in my policy area of responsibility, and with Samia Edmonds who chaired the HSSG Covid-19 Planning and Response Group.

Emergency Coordination Centre Wales.

14. I had no specific role in relation to the Emergency Coordination Centre Wales (ECCW). I would occasionally be copied into emails from the ECCW asking who would be appropriate to direct certain queries to.

Public Health Wales

15. From the outset of the pandemic I was aware of the role that Public Health Wales (PHW) had in the response to Covid-19. As I was not initially playing a major part in the public health response, I did not have a significant relationship with PHW or the Public Health Consultants it employed during much of the pandemic, this was managed by the CMO. My contact with PHW was mainly focused on Infection Prevention and Control (IPC) measures.

16. The UK IPC Cell was set up in January 2020 and Wales's involvement was led throughout by PHW. Dr. Eleri Davies, Head of Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme ("HARP") at PHW and Dr. Anna Louise Schwappach, Speciality Registrar in Public Health, also of PHW reported to the office of the CMO any changes at a UK level to the IPC guidance,

which was the guidance that applied in Wales as well. I had regular contact with both but less so with the wider PHW team.

NHS Chief Executive Wales.

17. I worked frequently with Andrew Goodall, in his role as Chief Executive of NHS Wales. Again, this primarily related to areas within my policy responsibility and the health care system but also, in relation to Covid-19, at times when I was acting as DCMO or deputising for the CMO. Andrew Goodall had regular meetings with the Chief Executives of the NHS organisations in Wales. Prior to the pandemic these were monthly but they were increased significantly during the pandemic, it think up to three times a week.

18. I was on the invite list for all these meetings and attended as often as I could to discuss and update on my areas of knowledge. Often, the CMO and I would both be in attendance. This would mainly be to ensure coverage of issues or discussion around an area in my policy responsibility. For example, I would attend to support discussions as they arose that may have related to critical care or end of life care due to policy changes or issues arising, or other policy matters known to me. Other occasions I would attend to deputise for the CMO. I considered these useful meetings involving two way sharing of information and updates.

Welsh civil contingencies fora, including the Wales Resilience Forum.

19. As noted above I had a limited role on the public health or civil contingencies side of things so rarely attended Welsh civil contingencies groups. The health protection team under the CMO would have engaged more frequently with this group but I do however recall at least one instance of attending the Wales Resilience Forum, possibly to deputise for the CMO.

Other individuals or committees within the Welsh Government involved in the response to Covid-19.

20. In terms of other individuals or committees working in and around the main response to Covid-19 there were a number of groups I attended or contributed to during the pandemic period.

21. I engaged with the health countermeasures group March/April 2020 in relation to PPE supplies for the health care sector. My engagement with this group tailed off as more formal arrangements and a PPE cell was established.

22. I recognised the need for a Nosocomial Transmission Group in April/May 2020 which I discussed with the CMO and this was immediately established with me acting as co-Chair with Jean White, Chief Nursing Officer. This group took responsibility for leading the infection prevention and control (IPC) response, along with physical estate signage and pathways, cleaning standards, data collection etc. It also discussed emerging evidence and publications, and provided a link to the UK IPC Cell who were drafting the continually evolving guidance published by the public health agencies and also discussed issues around PPE provision and deployment. I believe this group also provided an important role for information sharing, leadership and advice to Ministers and the wider system.

23. From May 2020 I also acted as co-Chair with the Chief Nursing Officer of the Nosocomial Transmission Group (NTG). A copy of the terms of reference for this group are exhibited in **M2BCJ01/04 - INQ000252576.** This group continued until 28 March 2022. The NTG and Nosocomial Policy team worked with stakeholders to develop a range of guidance, including on implementing IPC guidelines, Personal Protective Equipment (PPE), Covid-19 testing, cleaning standards, bed spacing, ventilation and environmental controls.

24. These groups included a range of NHS colleagues including from Health Boards, NHS Shared Services Partnership and Public Health Wales. Their purpose was information flow into and from Welsh Government.

25. CMO and I also met regularly with Chief Executives and Medical Directors, and the Academy of Medical Royal Colleges in Wales.

26. I did not have any significant engagement with the Covid-19 Project Team apart from when deputising for the CMO.

HSSG Covid-19 Planning and Response Group

27. The Welsh Government HSSG response was led by the HSSG Planning and Response Group and its underpinning structures. This group was formally

established by Andrew Goodall and Frank Atherton. I, along with other senior civil servants in the HSSG, was asked to comment on the proposed structure. I suggested the combining of primary and community care and prehospital and hospital care to help simplify operational oversight of these areas. A copy of the structure of this group is exhibited in **M2BCJ01/05-INQ000066199.**

28. I was a member of this group and the co-Chair of its subgroup the Acute Secondary Care Cell, a copy of the terms of reference for this group are exhibited in **M2BCJ01/06 – INQ000252578**. I acted as co-Chair of the Acute Secondary Care Cell with Andrew Sallows and NR This group discussed and planned the hospital response, including areas such as critical care, ventilators, continuous positive airway pressure (CPAP) devices, COVID treatment pathway, maintenance of essential services, field hospitals, end of life care etc. I believe this group played a key and effective role in planning the initial emergency response. By way of example of the work of this group, in March 2020 this subgroup undertook an ad hoc assessment of available invasive and non-invasive ventilation devices such as CPAP devices. This included beds with piped oxygen, oxygen concentrators, oxygen cylinders, and non-invasive ventilation or CPAP devices. A copy of the Sub-group's letter to health boards requesting this information on the 24 March 2020 is exhibited in **M2BCJ01/07 – INQ000226972.** This was form of reporting to the Sub-group was replaced by the NHS Daily Sitrep which was used to provide more routine reporting of oxygen devices available and in use.

29. I was a consistent member of the HSSG Covid-19 Planning and Response Group. My role was to contribute to the general discussions as a Senior Clinical Leader / DCMO within Welsh Government, but I was also present as co-chair of both the Acute Secondary Care and Nosocomial Transmission Groups. The Planning and Response Group was successful in drawing together into one leadership system the wide range of discussions and actions being taken by the subgroups, but I did not feel this group drove or directed that work, so was mainly a reporting and information sharing function. It was important though as the main point where the Welsh Government and stakeholders came together for common purpose.

Scientific Advisory Group for Emergencies (SAGE)

30. I did not attend SAGE nor did I have any communication with SAGE or its members.

Technical Advisory Cell and Technical Advisory Group

31. The main source of advice to Ministers was the Technical Advisory Cell (TAC), of which I became a member during 2020. Overall, my view is that there was excellent communication between Welsh Government and stakeholders, and also very close working relations between officials and Ministers, which resulted in a highly productive and responsive system.

32. I was not initially a member of Technical Advisory Group (TAG) but did receive invitations during 2020. I saw my role as being mainly to listen. I believe that TAG was successful in linking Wales to the SAGE discussions in England and in harnessing the academic expertise within Wales, as the agenda was frequently informed by the SAGE agenda beforehand. I did express some concern about the number of officials who were part of TAG as I felt there should have been clearer separation between advice and policy, given the risk of officials influencing professional and academic advice while also needing to take a dispassionate view of such advice before offering advice and options to Ministers. Each TAG meeting was chaired by Welsh Government officials with several officials contributing actively to the discussions alongside external academics and experts, and meeting notes and papers of advice were drafted by officials. I felt this made it hard to say that TAC was providing independent advice. I did raise this concern with Dr Rob Orford, who I recall felt it was more important that TAG enabled a co-productive and collaborative approach to the development of Ministerial advice, and I believe Ministers came to increasingly trust and rely on its advice, suggesting he might have been correct in his view. Ministerial advice should be based on several factors including the scientific evidence, but the scientific element discussed at TAG was not recorded separately. However, I do not recall any specific occasions when this led to decisions being made against scientific advice, but I was not present in the early days.

33. In terms of how complex expert, medical and scientific evidence, data and statistical modelling coming from groups such as TAG or SAGE was presented so

that it (or its implications) could be understood by Welsh Ministers and other, non-expert key decision-makers, I was not involved in all meetings providing advice to Ministers so cannot provide a complete answer and cannot speak for others. In meetings I attended, I attempted to explain in simple terms what was often a complex situation, with recognition of the degree of confidence of any understanding. The regular advice to Ministers from TAG usually included the level of confidence for any conclusion. Scientific and modelling work was often presented to Ministers without amendment, so included all academic caveats and discussion of study limitations.

Covid Intelligence Cell

34. The Cell's remit was to undertake surveillance with regard to Covid-19. The Cell's membership provided expertise from virology in Public Health Wales, the Welsh Government's Technical Advisory Cell and cross UK data and intelligence from the Joint Biosecurity Centre.

35. I recall attending the Covid Intelligence Cell only on an intermittent basis and cannot comment on its efficacy. It was chaired by a Senior Medical Officer from the office of the CMO so often myself or the CMO would have updates from team members as needed, for example if briefing Ministers or attending meetings with stakeholders.

Shadow Social Care Partnership Council

36. I do not recall attending meetings of the Shadow Social Care Partnership Council.

Other Chief Medical Officers / Deputy Chief Medical Officers

37. I participated in the UK Senior Clinicians Group from its outset and was invited to the UK Chief Medical Officers (UK CMOs) discussions from September 2020. I was an occasional contributor to the UK CMO WhatsApp group, to which I was added on 1 September 2020. I was involved in no other informal communications. There were multiple meetings between officials.

38. I met with the UK CMOs and DCMOs through the regular meetings of the Senior Clinician Group chaired by CMO England. I gradually became part of the UK CMO group, participating particularly when covering for the CMO, but also increasingly

as DCMO in my own right, after DCMOs had been included. I did not otherwise have regular meetings with UK CMOs or DCMOs, although there were occasional one-off meetings on specific issues such as antivirals use, criterial for vulnerable people testing, vaccination of children.

39. I believe a brief note was made of the Senior Clinicians Group by the CMO England office, but the UK CMOs / DCMOs group meetings were not otherwise recorded or minuted.

International organisations and other countries

40. I had no discussions with any other countries. As part of the TAG there was an international intelligence subgroup and within the CMO office there was an international evidence workstream lead by Gill Richardson and Cathy Weatherup who would oversee the international evidence coming in. We also had good links via PHW which were made through the International Association of National Public Health Institutes (IANPHI), of which PHW is a member. We also have some links, with the World Health Organisation (WHO). I was aware of these relationships and links but not directly involved.

Other individuals and organisations

41. As explained above there were multiple points of regular informal contact with the full range of stakeholders. On occasion I would accompany the MHSS to meetings with groups such as the Welsh Local Government Association (WLGA) or provide briefings for the WLGA.

42. I also issued letters to the NHS, particularly if covering for CMO or if there were changes of guidance which related to my areas of expertise. I would also write in my capacity as Deputy Chief Medical Officer, for example I wrote to all clinical leads in the NHS on the 17 March 2020 about decisions to suspend or reduce NHS activity due to Covid-19. A copy of this letter is exhibited in **M2BCJ01/08 - INQ000299020** On occasion, as necessary and following appropriate discussion, I wrote to social care providers, Royal Colleges and hospices as exhibited in **M2BCJ01/09 - INQ000299293**.

C. The information and evidence available regarding the nature and spread of Covid-19 in Wales

Sources of information and evidence available

43. Throughout the pandemic period there were a number of data sources coming into the Welsh Government. I personally received information from publications, and discussions at UK level or TAC. I believe that UK Senior Clinicians and TAC were effective for the consideration, discussion and provision of medical and scientific advice.

44. I also received regular data sets on the public health and NHS Covid-19 situation. This data was provided by PHW or via direct reporting by Health and Social Care Bodies into Welsh Government.

45. I was not involved in any structures established specifically for the discussion of data. I was aware of modelling updates from various sources within and outside Wales throughout the pandemic. The strengths and limitations of these approaches were known, specifically how the final modelled data depended on the assumptions being inputted into the model. Such assumptions included the impact of inherent viral transmissibility, changes in personal behaviours and, as the pandemic progressed, the impact of increasing immunity. The value of the models decreased marked during the pandemic in my view, due to the increasing complexity of all the inputted assumptions. I would where relevant refer to any limitations in the data various circumstances, mainly when providing an update to others as DCMO.

46. My recollection is that some modelling specific to Wales was produced by UK Health Security Authority (UKHSA) and that Swansea University provided the most detailed modelling relevant to Wales. TAC was the principal place in Wales where advice about modelling was discussed and I think was effective and was my direct source of modelling information, and models presented at TAC were often reproduced at different meetings I attended, for example the NHS CEO meetings, so I would hear them there also.

47. Due to the nature of my portfolio of responsibilities and the CMO's established relationship/responsibility for public health, there were occasions when I became aware that information was being passed to CMO but not to me and I sought to address that on each occasion, usually by request or reminder to the originating source of the need to copy me in, by email or verbally if on a teams call or in the office. I also reminded the CMO and CMO office of the need to keep me 'in the loop' as far as possible. I do not recall any requests being denied or not being adequate just some instances of communication of information to myself not being effective.

48. There was a general challenge that UK government or UKHSA rarely shared emerging policy so we were often had to respond after policy decisions had been made in England. I recall this being the case for changes in testing policy in health and social care settings and staff, but was the case for other areas as well. I believe it will be apparent to the inquiry that changes in Welsh policy frequently followed that in England, reflecting in large part the lack of joint discussions beforehand and the need often to keep more or less in line with England, given the flow of people across the border and our common professional communities.

49. I did not see economic advice as a matter of course. Societal aspects of policy were routinely considered in all advice, such as for shielding and school closure. TAC had a behavioural science subgroup that considered societal aspects of the pandemic.

50. TAC included a regular international update and this informed about the spread or Covid-19 and actions taken. This information was included in regular TAC updates to Ministers.

My understanding of Covid-19 and the available measures to control the spread of the virus

51. In terms of my understanding of Covid-19, I kept up to date on the continuously changing evidence on Covid-19 infection dynamics during the pandemic, the impact of new variants, and how this was measured and modelled. I did this by attending discussions of the UK Senior Clinical Leaders and CMOs, by listening to briefings from colleagues within the Welsh Government and PHW who were closer

to the developing evidence, and by reading papers sent to me. The route of transmission is droplet spread, which includes aerosols, infection is by cell entry in the respiratory tract, the transmissibility has increased with new variants such as delta and omicron and reinfection has become more likely as population measures have been withdrawn.

52. I understand the symptomatology of Covid-19 and how it has evolved with new variants, together with vaccination and antibody production after natural exposure, mainly achieved through the learning mechanisms described above. The wild type infection produced the classic triad of cough, fever and anosmia, but more recent variants have produced a less distinct clinical picture, but with less severe disease and death due to vaccination. I also understand the impact on health services, including hospitals, and the risk of severe disease and death, which has decreased during the pandemic due to greater public immunity.

53. In terms of the available measures in the early stages of the pandemic, I was not involved in the public health decision making at the start, and so am not able to comment on the options available at that time. As the pandemic progressed I was called upon to deputise for the CMO at times in relation to the review of the imposition and non-imposition of non-pharmaceutical interventions, but this was in respect of specific restrictions, such as facemasks, regional lockdowns and the Omicron variant. However, I do not think I was routinely involved in the discussion of the breadth of options over the pandemic period.

54. I am not able to comment on the timing of the initial lockdown but as noted above I was closely involved in decision about regional lockdowns in Autumn 2020 and then at the end of 2020 when delta emerged. Before the vaccination programme there was an appropriate concern about the risks of the disease particularly to the more vulnerable, and measures were taken with the aim of reducing this risk.

55. Decisions were taken on the basis of many considerations including data relating to community incidence and prevalence and hospital admission and bed occupancy numbers and available capacity. The modelling enabled estimation of the time when hospital capacity would be overwhelmed for instance, so was an important element in discussions.

56. My view was that the modelling was a helpful guide, but not absolutely reliable, particularly as the situation developed and became more complex. This complexity and associated uncertainty was laid out by the relevant scientists and minister were usually provided with their analysis without amendment. It was not used alone for decision making for these reasons.

57. The transmissibility of Covid-19 was measured in great geographical detail in terms of new cases, r values, hospital admissions, occupied bed numbers, death rates. These data assessed the net effect of all modes of transmission. I am not aware of any means of measurement of transmission that we did not adopt.

58. My understanding in all regards has evolved as the pandemic evolved. What has not changed is the mode of transmission of the coronavirus; there has been much written about aerosol spread but this is accepted as a part of the droplet spread model, and more likely in enclosed and unventilated areas. This has always been my understanding and has not changed during the pandemic.

59. In terms of whether I was aware of any divergence of expert opinion or understanding as to the nature and spread of Covid-19, there has been a range of expert opinion on all aspects of the pandemic throughout. Letters and emails were regularly received by colleagues within Welsh Government or within the NHS, setting out views held or received. Various views would be raised verbally in different settings and these would generally be discussed and replied to either at the time or later after discussion with relevant colleagues. Different views would be discussed in scientific groups. For example, TAC considered the efficacy of mask wearing on more than one occasion and the Nosocomial Transmission Group and UK IPC cell regularly considered the implications of aerosol spread. The conclusions varied depending on the evidence available – for instance masks were implemented at scale despite low confidence on their efficacy, but FFP3 masks were not advised routinely for everyone as the expert advice from the UK IPC Cell and elsewhere was that this was not appropriate.

60. Welsh Ministers were generally very sensitive to different views and would regularly request updated advice on specific issues, so our position was regularly updated in the light of our understanding of the evidence and communicated to

Ministers. Where I was asked to provide advice to those making the decisions on the nature of the public health response to Covid-19 then that would have regard for any variations in opinion from the scientific or clinical community, for instance to reference the strong view among some clinicians that either they had contracted Covid-19 or long Covid-19 through failings in personal protection within the NHS, or that FFP mask wearing should be mandated throughout the NHS, or even wider, to avoid aerosol spread. My formal advice was in the form of Cabinet papers for the 21 day review of the restrictions as I have outlined in more detail below at paragraphs 74, 83 and 93 with examples of my advice or advice I contributed to exhibited. As set out in the examples, included were recommendations from WHO, information on the position of the other nations and recommendations from the NTG group or other relevant stakeholders. Ultimately Ministers would need to consider the wider picture and information from wider sources, not just that from the CMO office and make the decision.

D. Early stages of the pandemic - January to March 2020

61. I became aware of Covid-19 around the same time as the rest of the world, when reports of a new respiratory virus in Wuhan started to appear in the press in early January 2020.

62. I was not involved directly in public health discussions during the early phase of the pandemic. As outlined above, my work concentrated on my pre-existing policy areas which generally related to the NHS response and medical professional leadership. The decision-making mechanisms have been discussed earlier in this statement.

63. In terms of any advice in this early period to Ministers or decision makers, as noted some of my areas of responsibility were related to Covid-19 such as infection prevention control measures, which included personal protective equipment (PPE) in relation to health care sectors. Mid March 2020 a request from Andrew Goodall came to me as a result of concerns expressed by the Cabinet that communication around PPE needed to be clear and professional so both staff and the public understood how and when PPE should be used. I worked closely with Eleri Davies from PHW in this respect and confirmed that additional work was being done to

develop simply FAQ and factsheets for both staff and the public. I also worked with Dr Eleri Davies from PHW to ensure that the information coming from the IPC cell was updated to colleagues in the Welsh Government quickly, ensuring that our comms and information to the health sector was up-to-date.

64. As noted above, my team also led on work around ventilators and again mid-March 2020 this was a real concern and one which Ministers wanted updates and information on. Following my letter requesting ventilator information on the 24 March 2020 as above exhibited in **M2BCJ01/07 – INQ000226972.** I provided information to Andrew Goodall around ventilator availability in Wales which he would take to the Ministers.

65. Therefore, while not directly involved in advising at Cabinet or other Ministerial meetings during these early stages, if a matter fell in my remit then I would be asked to provide information which would be fed to Ministers or included in briefings being prepared.

66. I was not involved in any discussions about the Stereophonics Concert or Scotland versus Wales rugby match.

67. As noted, I was not asked to provide advice directly to Ministers on these issues but I felt at the time that there was no real option but to advise the public to avoid mixing to avoid transmission, disease, the NHS being overwhelmed and a large number of deaths. I was concerned about schools closing and considered that we were making assumptions about transmissibility based on flu, but I could see that open schools would undermine the efficacy of a general lockdown. I do not know if a small change in the initial timing of the first lockdown would have reduced the overall harm of the pandemic, given Covid-19 represented a sustained risk to the population throughout the year until the vaccination programme became effective. I would note though that the timing of the initial lockdown was a matter for the UK government, as an earlier Wales only lockdown would not have been credible or effective.

68. I do not have any comment about the initial decision taken regarding international travel, apart from noting that such travel must necessarily cease as a part of the general national lockdown. Travel could have been ceased earlier but as above I

do not know the counterfactual, i.e., what overall impact that might have had on the overall course of the pandemic. As above I would comment that Wales is not in a position to make is own determinations about international travel, as most international travel into and out of Wales happens via airports outside Wales, and again a Wales only decision would not be credible or effective.

69. I am not in a position to comment on whether the medical and scientific advice in the early stages of the pandemic, January to March 2020, from SAGE in any way curtailed or prevented the Welsh Government from understanding the full scientific picture. My view as stated above is that early in the pandemic, Wales was not in a position to make separate major decisions ahead of UK Government, as these would not have been credible or effective. As time went on and we were able to draw on more locally relevant information and as more was known about Covid-19, I think each of the nations were able to make decisions separately, but we cannot disregard the possible futility of decisions in Wales to impose or not to impose restrictions when there is a porous border with England.

70. I did not think herd immunity was a safe and responsible approach to the pandemic, as it would have involved huge avoidable loss of life. I was not at any stage asked my view on herd immunity and did not offer one.

E. April 2020 onwards

71. As noted above, my role in relation to decision making on non-pharmaceutical interventions was minimal in the early part of the pandemic period. I do not recall being involved directly in advice on working from home and I was not significantly involved in discussion or advice on border controls.

72. The main areas on which I provided advice to Ministers and decision makers during the pandemic period and in respect of non-pharmaceutical interventions and in scope of module 2B were:

    a. The introduction of facemasks
    b. Regional lockdowns
    c. Christmas lockdown and variant of concerns
    d. Social distancing and isolation

Face masks

73. There were from around April/May 2020 increasing calls for mandating facemasks in the community. The CMO issued a statement on the 12 May 2020 in respect of face coverings in which he confirmed that he did not recommend the compulsory wearing of face coverings by everyone when they leave home and indicated that this should be a matter of personal choice. Whilst the CMO recognised some benefits to face masks, mainly in clinical settings, at the time of the statement PPE stocks were in high demand and the priority was ensuring sufficient supplies for hospital and care staff.

74. I had previously been involved in discussion about the use of facemasks in healthcare settings as a result of my responsibility for IPC measures and this had been discussed with the NTG. In February 2020 the CMO had written to Health Boards to confirm all healthcare workers managing possible and confirmed cases were advised to follow the UK IPC guidance for Covid-19. This guidance included instructions about different PPE ensembles that were appropriate for different clinical scenarios. Throughout the pandemic period healthcare workers were advised to follow this guidance. I understand the UK IPC Cell kept the guidance under continuous review in line with the emerging evidence/science and data. On the 2 April 2020 updated UK wide PPE guidance was agreed by the four UK CMOs, CNOs and Chief Dental Officers in the UK and endorsed by the Academy of Medical Royal Colleges. The updated guidance reflected the fact that Covid-19 was now widespread in the community, meaning clinicians were more likely to see patients with the virus. The update included new tables describing PPE use across different clinical scenarios and settings; advice on sessional PPE use and reusable PPE; change in close-contact distance; advice on washing forearms if exposed; advice on acceptable respirators; general formatting to improve usability. The UK Guidance on IPC and PPE in healthcare settings remained in use throughout the pandemic period.

75. In Wales we did not require the wide spread use of face coverings by the general public as soon as the other nations, for example this was introduced for all hospital staff as a legal requirement in England on the 15 June 2020 and from the 24 July 2020 for general use by the public in indoor settings in England.

76. The decision in England to mandate face mask wearing in all healthcare settings even in non-clinical areas went beyond the UK IPC guidance at the time. In Wales we were notified of this proposal by Dr Eleri Davies who had been informed of the proposal through her work on the UK IPC Cell. There was pressure to agree a four nations approach to the use of facemasks in hospital and non-clinical settings and on the 6 June 2020 it was confirmed via the Chief Nursing Officer for Wales that England would announce this policy change at 5pm that day.

77. Ministers did not agree to a four nations announcement. Ministers wanted to be clear on the advice from SAGE and the Technical Advisory Cell before agreement. The CMO was sceptical of the value of face mask wearing by the general public, and advice from TAG was that there might be a small beneficial effect with low confidence in this conclusion. We were conscious of the emerging risk to PPE supplies around this proposed decision and when made aware of this the Welsh Government ensured that these changes were fed into the demand model, taking account of other sectors such as social care as well before introducing the change in Wales. A key difference in Wales was that we already had mandated 2 meter social distancing, which applied in non-clinical hospital settings. The policy rationale for introducing mandatory facemasks or face coverings more widely in Wales needed to be fully rationalised.

78. Early in June 2020 the MHSS and First Minister requested advice on face coverings, particularly in light of requirements being introduced in England mandating the use in hospital settings and on public transport. A Welsh Government Action Group on PPE and Face Coverings was convened to consider the policy issues further in non-healthcare settings including public transport and schools. I attended this group and led on the guidance to policy teams. A summary from the first meeting is exhibited in **M2BCJ01/10 - INQ000215452** and the note to Ministers following the second meeting is exhibited **M2BCJ01/11 - INQ000299377.**

79. TAG advice in on the use of face coverings was received in June 2020. A copy of this is exhibited in **M2BCJ01/12 – INQ000066278**. This particularly highlighted that face masks and face coverings are different, and this difference should be emphasised in advice given to the public, and a consistent use of vocabulary ensured in communications from government. 'Face coverings' is an alternative term for a "non-medical mask" as referred to in the WHO guidance.

80. As outlined in the TAG advice the disadvantages of wearing face coverings should be communicated (e.g. difficulty for those who are deaf or have hearing impairments, skin problems, false sense of security). We did not bring in requirements as England had on the 15 June but were enabling vulnerable visitors to wear masks but not going further. We were considerate of the impact on those with disabilities (such as hearing loss) and that in the early part of the pandemic this was an evidence light area in terms of how effective facemasks would be in stopping the spread of the virus. This was however kept under continuous review.

81. The CMO provided advice to Ministers in June 2020 but I did contribute in terms of the information and advice coming from the NTG I chaired. A copy of the advice to First Minister is exhibited in **M2BCJ01/13 – INQ000281742**. On the 9 June the MHSS recommended use of 3-layer face masks in Wales but did not make them mandatory.

82. From the beginning of 27 July 2020 there was introduced a new legal requirement to wear face coverings on public transport. I was not involved directly in providing advice on this decision.

83. I was however closely involved in the decision to implement public mask wearing while covering the CMO role in late August 2020. A further updated TAG advice was issued on the 11 August 2020 which confirmed that the most recent NERVTAG paper suggested that cloth face coverings were likely to have some benefit in reducing the risk of aerosol transmission. Face coverings were noted to reduce the dispersion of respiratory droplets and small aerosols that carry the virus into the air from an infected person. They also provide some protection for the wearer against exposure to droplets but less protection against small aerosols. A copy of this TAG advice is exhibited in **M2BCJ01/14 – INQ000228031.**

84. On the 14 August 2020 the First Minister confirmed that when it is necessary, the Welsh Government would require the use of face coverings in more settings as part of a planned response to any incident or outbreak. It was a week or so after this that the CMO was on leave and I was covering his role. Facemasks were a significant topic for discussion following the TAG advice.

85. Wales had been more cautious than other countries about the benefits versus risks of universal mask wearing before this time, but the case incident rate reached 20 / 100,000 and was rapidly rising so I advised it was time to follow others and decide on implementation and Ministers agreed.

86. There were a number of informal discussions leading up to the announcement on the 26 August 2020 by the MHSS and Minister for Education recommending that face coverings are worn by "all members of the public over 11 years in indoor settings in which social distancing cannot be maintained, including schools and school transport". A copy of the statement issued is exhibited in **M2BCJ01/15 – INQ000300223**. This was based on advice from TAG on face coverings for children and young people under 18 in education settings, a copy of which is exhibited in **M2BCJ01/16 – INQ000066286**. Again, this was a recommendation not an requirement and all local authorities were asked to consider their estate and the feasibility of social distancing within them.

87. The First Minister subsequently issued a statement on the 11 September 2020 confirming that from Monday 14 September, all residents in Wales over the age of 11, would be required to wear face coverings in indoor public spaces, such as shops. A copy of the advice provided by myself on the 10 September 2020 is exhibited in **M2BCJ01/17 – INQ000281839**.

88. At this point the decision to amend the advice to NHS Wales was made noting that now that there is a new mandate across Wales for the use of face coverings in indoor public spaces, all staff working in health and social care settings in Wales should now wear medical grade facemasks in non-clinical settings. Advice was provided to the Minister for Health and Social Care on the 23 September 2020 which was cleared by myself. A copy of this advice in exhibited in **M2BCJ01/18 – INQ000145013.** The Minister agreed to the proposals and a letter was issued by

Andrew Goodall to the NHS on the 28 September 2020, a copy of which is exhibited in **M2BCJ01/19 – INQ000227252.** The guidance was clear that this was in addition to social distancing , hand hygiene, frequent surface decontamination and other measures to reduce the risk of spread of Covid-19 which remained key and must be reinforced.

89. Throughout the remainder of the pandemic period the rules around facemasks and settings in which they applied changed but my involvement was limited.

Regional lockdowns

90. Around the same time as the issues around face coverings I also became closely involved in the period of regional lockdowns across Wales as covering for CMO during a period of his leave at the time.

91. On the 8 September Caerphilly County Borough Council became the first local authority area to become subject to the regional or "local lockdown" in Wales. Following this there was data coming in from PHW which was concerning about Rhondda Cynon Taf and the Merthyr Tydfil areas and I was given the 'heads up' as a result of which I started discussions across the Welsh Government. We kept a close eye on the numbers in these areas and during this time I regularly met (virtually) with the MHSS to ensure he was updated.

92. Data was coming in daily on the figures and the Ministers were at this time doing lunchtime press conferences so timely and up-to-date information was essential.

93. The data we were receiving within Wales was highly granular data and had to respond to high levels of anxiety in Local Authorities in some localities when their case rates were rapidly rising. On the 22 September 2020 local lockdown measures were introduced in Blaenau Gwent, Bridgend, Merthyr Tydfil and Newport.

94. Regional lockdowns were an attempt to manage spread without the need for a national lockdown, but ultimately did not achieve this.

95. By the Autumn of 2020 I was attending regular meetings with Ministers and was aware of but not centrally involved in discussions regarding a 'firebreak' type

lockdown. As in the matter of national lockdowns, Wales has had limited independent ability to make earlier decisions than UK government in the Autumn without any financial cover for the economic impact by the UK government. However, there was a clear need to intervene at the time as case rates were escalating rapidly to high levels, so I supported a decision to intervene. Unfortunately, UK government took no action and offered no support including no financial support, The firebreak was ultimately shorter and less impactful than would have been ideal because of the lack of support from the UK government.

Christmas 2020 and variants of concern

96. I also played a role in the decision making prior to the national lockdown at Christmas 2020, joining the First Minister for the press conference when he announced it. In November 2020 plans had been agreed on a four nations basis about Christmas and the use of Christmas bubbles for a five-day period over Christmas. However, we were advised on the 14 December 2020 by the CMO England office that a variant of concern had been identified in England and would be discussed at the UK CMO meeting later that day. Ministers were informally briefed pending further information being assessed by PHW. I attended Cabinet on the 19 of December 2020. This meeting took place on a Saturday and was held in response to concerns about this new variant of the virus. The CMO was not available to attend. The First Minister advised that the Prime Minister would be announcing later that afternoon, significant new measures to control Covid-19 in London, Kent, Essex and the East of England and changes to the arrangements over the Christmas period for the rest of England. A decision was needed about the approach for Wales. I was asked at this meeting to provide the latest advice in respect of the new strain of the virus and the impact that this would have on the NHS. In Wales there were high and increasing incidents in almost all areas particularly in the South. Of the current sample of cases available the highest proportion of cases testing positive for the new mutation was in North Wales suggesting a reservoir of cases that we knew had the new mutation. This new mutation was possibly 70% more transmissible so a significant concern. The minutes of this meeting are exhibited in **M2BCJ01/20 - INQ000048803**.

97. Cabinet agreed to bring forward "Alert level 4" restrictions for the whole of Wales. This was the higher tier of restrictions and would result in the closure of retail and hospitality services. It was also decided that the previous five-day period for Christmas bubbles would be reduced to one day.

98. This was clearly a difficult decision for Cabinet to take, when people were looking forward to some respite from the pandemic impact. I recall the First Minister was determined that all Ministers' voices were heard and respected. I do not recall major dissent from the advice that action was needed, even at this important time for families and friends, and the proposals announced were agreed by all. After the Christmas period the variant remained a significant concern and the MHSS requested regular updates on what the science was saying and what impact this would have on guidance and information for the public. For example, I was asked to provide information on whether the variant required updated/alternative IPC measures, once provided the MHSS asked for this advice to be summarised and circulated to all the Ministers as there were increasing calls coming in from all areas on how the variant needed to be addressed. A copy of my advice to Ministers is exhibited in **M2BCJ01/21 – INQ000299753**

Social distancing and isolation measures

99. I also provided some advice to Ministers on social distancing and recall advising Ministers about the increased risk of social distancing at 1 meter. I also provided advice to NHS facilities on social and physical distancing in premises and hospitals.

100. I also responded to a request from Baroness Finlay and colleagues at the Bevan Commission, to deliver the 'Distance aware' badge and marketing campaign. The idea was promoting the wearing and recognition by others of badges to signal that the badge wearer wants to keep a safe distance from others. This involved gaining urgent agreement by Ministers that I could ask NHS Shared Services Partnership to procure and help distribute the necessary materials. Ministers were keen that this was not just aimed at those shielding but to anyone who made the personal decision to want a safe distance to be maintained recognising that while restrictions may have been eased many people were still anxious.

101. Although I was not closely involved in providing advice on schools closure, I became gradually more involved in policy discussions and ministerial advice regarding schools, particularly in early 2021. I worked increasingly closely with Education policy colleagues and became a regular attender at meetings with the Teaching Unions, where my clinical communication was considered helpful. My involvement was mainly in relation to protective measures within schools as they returned and attempting to ease anxieties.

Data and information for decision making on NPIs

102. I am not aware of specific times when there was a lack of data for decision making. I think that the Welsh Government worked remarkably well, but there was a lack of information from UK government throughout, which caused us many times to be following England, when we could have worked and made decisions together. There was clearly a problem with UK government support for lockdowns in Wales when UK government were not taking action themselves.

103. I do not recall any problem with co-ordination within the Welsh Government or Wales and I am not aware of problems encountered with strategy or planning. I would note though that Welsh Government is essentially a small government and I, like many others, was working flexibly and across many policy areas to ensure any gaps were covered.

104. The Welsh Ministers were extremely aware of our inequalities in Wales and the impact of Covid-19 on the vulnerable throughout the pandemic. I was closely involved in the early phases of the shielding programme and participated in some of the discussions about risk stratification at the Senior Clinicians Group. I also recognised early on the need for particular attention to the poorer outcomes for Black Asian and Minority Ethnic communities and staff in health and social care services, establishing the Black Asian and Minority Ethnic advisory group and asking one of our clinicians to development the Risk Assessment tool to guide clinical practice and deployment conversations for health and social care staff. I worked with workforce policy colleagues to implement the risk assessment tool and seek to minimise harm to Black Asian and Minority Ethnic staff across the public sector.

105. I am unable to recall decisions being made in Wales that I did not agree with.

106. I was not affected by, or indeed aware of, any funding limitations in advice I provided to Welsh Ministers. I am aware the Chief Economic Adviser was providing advice to Ministers, but I do not recall his involvement in any advice I was providing.

107. I attended many meetings with Ministers alongside the Chief Scientific Adviser for Wales. He took a leading role in providing advice, particularly later in the pandemic, when he was working full time on it, while I was covering many other policy areas.

108. Learning from other countries I do not feel I can comment about the early phases of the pandemic as was not generally involved in advice to Ministers but as I outlined above there were others in the CMO office who were working on this.

F. Divergence

109. There was divergence during the Summer of 2020 when UK government were encouraging people to eat out and mix socially, and frustration with a lack of action as case rates increased during the Autumn prior to the firebreak. The firebreak decision was clearly a difficult one for Welsh Ministers as intervention was needed with no financial backing from UK Government. The decision for a firebreak was the right one in my view but by reason of the lack of UK government funding it was too short to be effective for sustained benefit. I do not have a view as to whether the divergence occurred at the right time or not. Throughout the major parts of the pandemic, Welsh Ministers appeared more risk averse than Ministers in UK government, Wales adopting a similar stance to that seen in Scotland.

110. Divergence I believe was necessary, particularly once we had the local data and information to consider in the later period of the pandemic. The Welsh Ministers were able to work very closely with the stakeholders and communities in Wales to co-produce policy that was very sensitive to local needs in Wales. I recall also that there was greater public confidence in the stance taken by Welsh Ministers than by Ministers in UK government.

111. I cannot think of any instances where divergence worked well or when it did not. Divergence was necessary and responsive to local needs so it would be difficult to assess what the impact would have been had the four nations aligned. As I outlined above, where divergence would not have worked would be on issues like international travel given the location of ports in England which also service people travelling to or from Wales.

G. Public health communications

112. I undertook an increasing role in communications as the pandemic evolved. During the first year I undertook media TV or radio interviews only when deputising for CMO. As outlined above, in December 2020 I stood alongside the First Minister when he announced the second national lockdown during the Christmas period. In early 2021 also I undertook further press conferences with the Minister for Education on 3 occasions relating to returning to school and keeping learners safe, and the Health Minister relating to the spread of the Delta variant I also undertook radio and TV interviews either when the subject matter fell within my area of responsibility, such as infection prevention and control measures, or more generally when the CMO was not available.

113. I am not aware of any public communications that departed from advice given by me.

114. I felt the First Minister was extremely effective in explaining the background to decisions made. I did not always feel that officials were as effective, sometimes focusing too much of the numbers or details, and perhaps not having had the media experience of Ministers.

H. Parliamentary evidence

115. I have not provided evidence to any other inquiry or parliamentary group, committee or body.

I. Public health and coronavirus legislation and regulations

116. I did not play a significant part in advising on the development of coronavirus legislation. On those occasions where I provided advice to Ministers or Cabinet

which resulted in a Ministerial decision which required the coronavirus legislation to be amended or enacted I was not involved in the later process of drafting or instructing legal colleagues.

117. Occasionally the CMO may ask for a view on the changes introduced and share information from the Office of Legislative Counsel (OLC), and example of this is set out in exhibit **M2BCJ01/22 –INQ000299129** in which the CMO asked for any thoughts on the proposals for the 2 meter guidance which was being put before Cabinet by officials.

118. Additionally, the public health powers that were used to place restrictions in Wales would require advice from the CMO and later in the response a 'CMO statement' became part of the established process. Where the CMO was not available I would provide this advice to Cabinet. I also played a part in decision with other UK CMOs on setting the UK alert level, when CMO was not available.

119. To my recollection there were no regulatory proposals or recommendations that I did not agree with.

J. Lessons learned

120. The Welsh Government was learning all the time about the virus but also about the way it behaved and the mechanisms needed to curtail its spread. There are several such examples. It was initially felt that cold surfaces were important in transmission but this concern lessened with time. There was learning from the lack of long term impact of regional lockdowns, which were not repeated.

121. For many months the pandemic was managed by the policy team for public health, with minimal increase in policy support. The Welsh Government seemed slow to realise the need for a whole government response and that a pandemic cannot be run from standard resources in 'peacetime' health.

122. Related to this point, I think it is important to understand that a DCMO, even if not trained in public health, needs to be included in the public health response from the start with access to all the information sent to the CMO, to facilitate the deputising role. While I did deputise for the CMO on a number of occasions there was an assumption that I was privy to the same information that the CMO received

from organisations such as PHW but this was not always the case and there would be a need to hunt out information at pace. It was also not always clear what information was or was not needed to support particular roles within the Welsh Government.

123. I think that strengthening lines of communication going into CMO and ensuring this is accessible to the wider team and particularly those deputising is essential to ensure robust responses in emergency period. Thankfully while at times inconvenient, this did not delay or prevent appropriate and timely advice being provided by myself to Ministers or officials but there is work that could be done to improve that aspect of the response.

124. In terms of what worked well during this period, while there are many things I think worked well across the government, from my personal perspective I think it is important to recognise the vital role played by the CMOs led by CMO England, who acted closely together as a force throughout in minimising unnecessary divergence. This meant that there was some consistency in the advice sent to Ministers across the UK.

Statement of Truth

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

Personal Data

Signed: _____ _____

Professor Christopher Jones

Dated: _____30/10/2023_____