Witness Name: Joanna Jordan
Statement No.: M2B 1
Exhibits: 24
Dated: 5 December 2023

**UK COVID-19 INQUIRY**

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**WITNESS STATEMENT OF JOANNA JORDAN**

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I, Joanna Jordan, will say as follows: -

**Preface**

1. The purpose of this statement is to assist 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/JJ2/01**, will cover the period from the 1 March 2020 and May 2022.

3. To address the Inquiry's request for evidence on the matters outlined this statement I have considered the contemporaneous documents held by the Welsh Government that are relevant to the questions asked. As explained below, throughout much of the significant period I was working within the NHS Wales system and not within the Welsh Government. I am now retired and no longer have access to documents prepared and stored on the NHS Wales system. As a result I have been very reliant on my recollection.

**Background and qualifications**

4. I have an ONC Business Studies (with distinction) with associated A level passes in Accounts and Law and a Chartered Institute of Management

Accounting (CIMA) foundation. I am a Qualified PRINCE II Practitioner and following nomination by Welsh Government/Cabinet Office have also participated in a number of Public Sector senior leadership schemes.

5. I joined the Civil Service in 1980 as an Administrative Officer working in Personnel Management Division. I also undertook a number of short secondments around this time to the Secretary of State's for Wales' Private Office in Whitehall.

6. I then held the following posts as I progressed to the Senior Civil Service: Executive Officer, Planning Appeals Unit (1983-85); Assistant Parliamentary Clerk Secretary of State for Wales' Private Office, London (1986-87); Executive Officer, Permanent Secretary's Division (1987-88); Higher Executive Officer, Energy, Steel, Coal and Telecomms Briefing Unit (1988-91); Higher Executive Officer, Financial control and monitoring (1991-95); Senior Executive Officer/Executive Band, Head of Financial Planning Team (the Welsh Treasury) (1995-02) and Head of Crime Reduction Team (2002-04).

*Deputy Director, Community Safety Division, Local Government and Communities Department (Nov 2004 - July 2010)*

7. I joined the Senior Civil Service in November 2004 as Deputy Director, Community Safety Division, Local Government and Communities Department.

8. With an annual programme budget of £70 million I led the development and delivery of Welsh Government's strategies and policies in relation to:
   - Tackling Substance Misuse
   - Domestic Abuse and Violence against Women
   - Youth Justice
   - Fire and Rescue Services in Wales
   - Community Cohesion and Contest.

9. The role included developing partnership working with local authorities, local health boards, Public Health Wales, the police, fire, prison and probation services, National Offender Management Service, Youth Justice Board, youth

offending teams, voluntary sector organisations and service users. During this time I led on the establishment of Community Safety Partnerships (Crime Reduction Partnerships) in Wales and the Substance Misuse Area Planning Boards.

*Director of Mental Health, NHS Governance, and Corporate Services (July 2010 – November 2019)*

10. From July 2010 until November 2019 I was the Director of Mental Health, NHS Governance, and Corporate Services within the Health and Social Care Group. I reported directly to the joint role of Chief Executive of NHS Wales/Group Director General and I had direct responsibility for an annual budget of over £60m.

11. My role involved a sensitive and complex policy agenda, NHS leadership and scrutiny functions, alongside a range of group-wide corporate responsibilities. I was involved in close engagement with Welsh Government Ministers, other Welsh Government and Whitehall senior officials, NHS and local government leaders, police commissioners, voluntary sector leaders, service users and carer representatives. My key areas of responsibility included:

- Leading the development and delivery of the Welsh Government's legislation, strategies and policies for adult and children's mental health, substance misuse and the healthcare needs of vulnerable groups (including veterans, offenders, refugees and asylum seekers). This includes the scrutiny of NHS organisations planning and performance in these areas.
- Leading on providing advice on NHS Governance issues and developing related legislation, policy and guidance.
- Oversight of co-ordination of intervention for LHBs in Special Measures
- Leading cross-border and EU policy matters (including Brexit)
- Overseeing all internal and external communications for the Group
- Oversight and management of all health and social services-related Government business, support to Ministers and FOI handling.
- Leading a range of corporate functions for Group, including internal corporate governance, risk management, HR functions and GDPR implementation.

- Providing support to the DG on a range of sensitive and novel issues.
- Leadership and management of the Welsh Government's statisticians and social researchers.

*National Programme Director for Mental Health – NHS Wales (November 2019 - March 2021)*

12. During November 2019 until March 2021 I was seconded from the Welsh Government to NHS Wales. I was able to take my experience and knowledge from my previous role and bring that into the NHS.

13. I was seconded to the NHS Collaborative which was hosted by Public Health Wales. The NHS Collaborative was at that point run by the Chairs and Chief Executives of NHS bodies in Wales. I am not a mental health clinician but I drew on clinical expertise where necessary, and during the Covid-19 pandemic worked closely with Shane Mills, Clinical Director of the National Collaborative Commissioning Unit (NCCU) who is an experienced psychiatric nurse. I set up a "Mental Health Co-ordinating Centre" to enable myself and my team to work collaboratively and seamlessly with NHS bodies in Wales (in partnership with Shane Mill- acting as Clinical Adviser and his team- in the NCCU, mental health expertise in the Delivery Unit and Improvement Cymru). As well supporting NHS bodies, this facilitated a one stop shop/co-ordinated response in working with the Welsh Government, the voluntary sector and other relevant stakeholders during the Covid period. The actions described in this statement were all taken under these temporary arrangements.

14. Prior to Covid, my secondment role was to drive the delivery of the Welsh Government's mental health strategy across NHS Wales. My secondment role was established as part of the plans to develop the NHS Executive for Wales. The NHS Executive for Wales was conceived as a response to the Parliamentary Review of Health and Social Care in Wales of January 2018 which recommended that a new national executive function be created in NHS Wales to provide a clearer distinction between the national executive function strategically developing and managing the NHS, and the national civil service function to support delivery of the NHS and Social Care priorities. Work on the NHS Executive was paused,

towards the end of 2019 to ensure that available resources were focused on urgent and significant matters. Initially this was the Welsh Government preparation for a no deal Brexit and then in spring 2020 response to the Covid-19 pandemic.

15. Throughout my secondment I reported to Carol Shillabeer (the then Chief Executive of Powys Local Health Board) who was the lead Chief Executive for Mental Health Services in NHS Wales. I also continued to report to Andrew Goodall in his role as Director General Health and Social Services (DG HSS) and Chief Executive NHS Wales (CEO NHSW) in terms of my performance and development as a Civil Servant.

*Head of Health and Social Care Group (part time) (April 2021-May 2023)*

16. In this role I worked under the DG HSS and CEO NHWS which was Andrew Goodall initially and then from November 2021, Judith Paget. This involved supporting on a range of tasks on behalf of the DG HSS/CEO NHSW including leading restructuring of group and Programme Director for the development of the NHS Executive for Wales.

**Initial Response to the pandemic January – March 2020**

17. I was aware of the emergence of Covid-19 in China in January 2020. At that stage, I was not involved in the Welsh Government or the NHS Wales discussions or response to it.

18. Between January 2020 – March 2020 I was focused upon the planning for the delivery of the Welsh Government Mental Health Strategy and agreeing the priorities for the delivery of that strategy with the NHS Chief Executives and other key players. I worked to secure the resources and staffing required for the Mental Health Network team for which I was responsible.

19. I was on holiday in March 2020 when I received telephone calls and messages from my team in the NHS Wales about the developing Covid-19 situation within the UK at that time and the need for action to be taken in response. As I recall,

these were on my Public Health Wales-issued work phone and I did not find any of these messages on my personal phone.

20. From informal discussions I had with colleagues within the Welsh Government, upon my return from holiday on 14 March 2020 and early the following week, it was clear to me that the emerging pandemic was taken seriously and at the top of their agenda. The first lockdown agreed by the Welsh Government was announced on 23 March 2020. However, as a result of my secondment, I was not involved in the Welsh Government's immediate response to Covid-19 including the discussion around this or subsequent lockdowns. Nor can I comment on the information or modelling available to those within the Welsh Government responsible for the development of its initial strategy.

21. Whilst I did not draft public health communications, where they touched specifically on mental health services they would be shared with me for comment and to provide advice about what should be included within them. My role as a (via the Co-ordinating centre) between the Welsh Government and the NHS allowed me to share them with NHS colleagues for comment.

**Engagement with Welsh Government and others**

22. During the pandemic I used my long experience as a senior civil servant and my position at the time to provide assistance to Welsh Government officials on mental health issues where I could, but I did not hold a decision making or formal advisory role and I did not attend any decision-making meetings such as Cabinet or the Executive Committee (ExCo).

23. Within the Welsh Government, I spoke regularly with Joanne Daniels (Director for Mental Health Services) and Tracy Breheny (Deputy Director for Mental Health Services). During the initial stages of the pandemic we spoke daily, moving to several times a week as the situation developed.

24. I assisted in the drafting of instructions to the Welsh Government's Office of Legislative Counsel on the exceptions within the Coronavirus Regulations as they related to mental health services. The regulations included a requirement for

certain business and services to close so my role primarily focused on what was covered under the term mental health services so there was clarity for the sector given the range of services this potentially covers. I also provided policy input on and participated in discussion on whether or not Wales should utilise powers under the Coronavirus Act 2020. These powers essentially enabled the Welsh Minister to make temporary modifications to the Mental Health Act 1983 using secondary legislation or regulations, as they are usually referred to, in an emergency period for the purpose of preventing delays in admitting people to hospital for treatment in the event that a large number of psychiatrists and other professionals ceased to be available to perform their functions. These modifications worked by allowing functions relating to detention and treatment under Mental Health Act to be satisfied by fewer doctors' opinions or certifications. Amendments could also allow for the relaxation of certain time limits relating to the detention and transfer of patients. These powers were considered as a last resort option and while discussed these regulations were not ultimately implemented.

**Engagement with UK Government and counterparts**

25. I attended the following key groups and meetings as a representative of the NHS though I no longer have access to papers or minutes for the majority of these:

    a. The Welsh Government led Mental Health Incident Group (see below);
    b. Directors of Mental Health Services - I established and chaired (initially twice weekly) then weekly meetings with the Directors of Mental Health Services in all LHBs in Wales.
    c. These meetings were also attended by a Welsh Government representative from the Mental Health Policy Team and Shane Mills of the NCCU. These meetings were aimed at:
        i. ensuring that first hand information on the situation in services across Wales,
        ii. Sharing best practice and solutions to issues facing LHBs individually or collectively
        iii. Sharing proposed guidance or funding proposals for immediate feedback.

d. Heads of CAMHS services – I also met with the head of the Child and Adolescent Mental Health Services (CAMHS) on the same basis as I would meet with the Director of Adult Mental health, i.e. to share information, best practice and guidance.

e. The Wales Alliance for Mental Health met initially twice monthly, reducing to monthly. Welsh Government officials representing health, equality and related policy areas met with voluntary organisations, myself as the National Programme Director for Mental Health and the NCCU. By way of an example the minutes of a meeting of the Wales Alliance for Mental Health are exhibited at **JJ2BWG01/01-INQ000239512**.

f. The mental health team within the Department of Health arranged meetings between mental health leads or representatives from each of the four nations and their respective Public Health bodies. NHS England also attended. These meetings occurred every two weeks (as I recall). The meetings took a collaborative approach, with all of those trying to share information and best practice, collaborate where we could and to coordinate where we were commissioning research to avoid duplication. Agendas and minutes were prepared by DoH England. Any relevant information from this meeting was shared with MHIG or Mental Health Team in the Welsh Government directly.

26. I am aware that there was direct liaison between Department of Health and the Welsh Government Mental Health Team but I was not involved in those discussions save for, as described above.

27. Shane Mills and I had a good working relationships with many of those who worked in mental health services within the other governments and so I was able to contact them and informally discuss discrete issues with them as required.

28. I cannot speak to every decision taken within the NHS in Wales or the NHS in England but I am not aware of any significant or deliberate divergences in the approach taken to mental health services apart from the commissioning of bespoke mental health surge beds.

**Informal Communications**

29. I was not a member of any WhatsApp or other messaging groups with Welsh Ministers, senior advisors, and senior civil servants.

30. I have no notebooks from the relevant period. During my secondment I used a Public Health Wales-issued phone, after my secondment I used a Welsh Government-issued phone, and I used a personal phone throughout the relevant period.

31. Though I did not often use my Public Health Wales work phone, on occasion I used it to send text messages of an administrative nature to colleagues, such as whether a person would be joining a meeting. I do not recall using this phone to send direct WhatsApp messages however I cannot completely rule out doing so. Any WhatsApp messages would also have been of an administrative nature. I operated the phone on its default system settings and did not proactively delete messages. The messages did not have significant bearing on substantive work and were not separately saved on the network. The phone was returned to Public Health Wales when my secondment ended in March 2021. I am not aware of what happened to the phone or its contents after the phone was returned, and I am now retired and outside of the organisation.

32. I did not regularly use my Welsh Government work phone and cannot recall using it for any informal or private messages relating to the Welsh Government's response to the pandemic. I operated the phone on its default system settings and returned the phone to the Welsh Government in late May 2023 just prior to my retirement. I understand that, when Welsh Government mobile phones are returned (for any reason), for reasons of security, the data on the phone is wiped within a day or two of being handed back, data is not backed up and there is no 'profile' as such on phones to recover. Therefore, I cannot retrieve the contents of this phone to check for any informal or private messages.

33. I did have on my personal phone contact details of a few people I worked closely within in the Welsh Government and the NHS and exchanged direct text messages on my personal phone, but we did not exchange messages

providing commentary or remarks about decisions about to be made or decisions about to be taken or policies or decisions taken already by the Welsh Government in relation to Covid-19. I operated this phone on its default settings and did not delete any of these messages. I am in possession of this phone, I have reviewed its contents and I will arrange disclosure of these messages relating to the Welsh Government's response to Covid-19.

34. I did not engage in any other form of informal or private communication, including private emails with Welsh Ministers, senior advisors or senior civil servants, regarding the Welsh Government's response to the pandemic.

**Collecting data and statistics**

35. In a letter dated 14 April 2020 Andrew Goodall emphasised the need to ensure that essential mental health services were continued and that arrangements were in hand to collect service updates and minimum data requirements. This letter is exhibited in **JJ2BWG01/02-INQ000227096**.

36. Discussions were held with all local health boards (LHBs) about the need to make appropriate provision in terms of critical care need. Discussions were also held with all LHBs to ensure core mental health services were protected.

37. One of my key priorities during the pandemic was the collection of real-time data on mental health services to inform the Welsh Government's planning. It was recognised that it was important to collect this data in a consistent manner and the only way to collect the necessary data was to do so manually **JJ2BWG01/03-INQ000239490**.

38. On behalf of NHS Collaborative, I circulated templates to both adult and child mental health services on 14 April 2020, **JJ2BWG01/04-INQ000239491 and JJ2BWG01/05-INQ000239492**. The templates were developed to capture the level or components of services that adult and child mental health services were delivering as well as any additional detail. They were amended as required in response to feedback received. This included requirement of confirmation that essential services were being delivered and service risk assessments. The

templates were circulated to LHBs who would complete it and return weekly. The data was collated and shared weekly with the Welsh Government. This data would inform the discussions in the MHIG meetings. The reports were published in the password protected areas of the Mental Health Co-ordinating Centre website so that LHBs were able access the information easily and see the position of other LHBs.

**The Mental Health Incident Group**

39. The Covid-19 Mental Health Incident Group (MHIG), also known as the Mental Health Cell was established in in March 2020 in response to the pandemic. The MHIG met at least weekly and oversaw the delivery of actions in an agreed work plan and received assurance reports on the capacity and capability of mental health services whilst formal performance management reporting has been stood down. The MHIG was convened by, and is chaired by, the Welsh Government, namely Joanne Daniels. The membership of the MHIG consisted of representatives of the following organisations:
    a. Welsh Government
    b. NHS Collaborative Commissioning Unit
    c. Public Health Wales
    d. NHS Delivery Unit
    e. Welsh Health Specialised Services Committee (WHSSC)
    f. ADSS Cymru
    g. Social Care Wales (SCW)
    h. Health Inspectorate Wales

40. The MHIG was part of the wider Covid-19 planning and response structure and fed in to the:
    a. Primary and Community Care Group
    b. Acute and Secondary Care Group
    c. Social Services Group
    d. Cross WG Vulnerable People group
    e. Workforce Group
41. I was not otherwise directly involved in any of those groups.

42. The MHIG did not replace existing mechanisms and governance arrangements in health boards, but aimed to provide support and guidance at a national level and to resolve escalated issues of concern. In these meetings the most up to date modelling and statistics were shared, together with the advice received from TAG/TAC. I exhibit a copy of the MHIG Draft Scope as **JJ2BWG01/06-INQ000182587.**

43. I attended MHIG meetings as a representative of the NHS Wales, not as a representative of the Welsh Government. My team in the NHS presented and discussed the data we collected, which was later supplemented by the NHS bed capacity report.

44. I provided the MHIG with updates about the progress of the four nations on specific issues that were discussed during the Department of Health meetings I attended with my counterparts in those nations (described above). See for example **JJ2BWG01/07-INQ000239515.**

45. In April 2020 Phil Chick (Assistant Director, Mental Health, NHS Delivery Unit led on drafting a paper on the *"Essential Services"* following discussions with the MHIG, as exhibited in **JJ2BWG01/08-INQ000239511**. This was communicated to services by the Chief Executive NHS Wales on 14 April 2020. The paper identified essential service components in mental health, learning disability and substance misuse services, including sub-specialties that are deemed to be critical for LHBs to sustain during the Covid-19 pandemic. It also set out a marker that where LHBs and their partner local authorities were unable to sustain the defined level of service they could raise concern in situation reports which could be used to consider the risk mitigation steps that were necessary. The ability of LHBs to deliver against these essential services was monitored in the weekly data collection reports to enable us to have early warning of any significant issues.

46. In May 2020 I was drafted an outline recovery planning framework for mental health services. This was subsequently discussed with LHBs Covid 19 leads **JJ2BWG01/09-INQ000239544**. This framework was finalised and overseen by

the MHIG. Progress against the agreed actions was discussed at MHIG meetings and communicated to LHB Covid-19 leads in fortnightly calls. It was intended that this framework would structure the MHIG review of lessons learned from the pandemic. I was not involved in that aspect of its work having by that time returned to work in the Welsh Government and having had a period of compassionate leave towards the end of 2020.

**Sharing best practice**

47. From the earliest days of the Covid-19 response I worked closely with Shane Mills of the NHS Mental Health Collaborating Commissioning Unit to engage with LHBs to discuss and to share the practices and procedures they developed, and to try to find answers to any questions they raised.

48. To do so we developed a website to support the Mental Health Co-ordinating Centre as a means by which we could share knowledge and best practice with all of those working within mental health services in Wales quickly. As the NHS Collaborative Website sat on the overstretched Public Health Wales website it could not accommodate this additional website as well. We therefore hosted this platform on the Welsh Ambulance Service Trust website.

49. The website could be accessed by all those authorised to do so in LHBs services. Myself, Shane Mills and certain members of our team had editing rights. The voluntary sector could also access certain elements, such as the published guidance. The website was administered by a member of Shane Mills team who would publish daily updates after Shane Mills and I had reviewed the questions received and agreed the response, seeking guidance from elsewhere where necessary. Questions could be submitted on the website or sent to Shane or I directly. The Website included the latest data reports, latest guidance and a host of answers to questions and issues facing services. We would also obtain copies of any useful guidance developed at a local level **JJ2BWG01/10-INQ000239479** and publish it on the platform so that others could access and learn from it.

**The effect of NPIs and the equality considerations**

50. I did not provide formal advice to the Welsh Government on the use of non-pharmaceutical interventions, and it was not my responsibility to make decisions about their use. I do not recall any formal input into equality impact assessments. My only involvement would be in so far as they were discussed in the MHIG meetings. From memory the only relevant discussions would have been to agree or discuss the criterion for face-to-face appointments and so the exceptions to the lockdown regulations.

51. As my remit was focused on mental health services, I was acutely aware, as was everyone working in the field, that we were considering those with protected characteristics under the Equality Act 2010: those with mental health difficulties, learning disabilities and children and young people.

52. We ensured that they could continue to access community mental health services by developing the essential services guidance, discussing the ability to use online tools and platforms etc. This included how telephone appointment could be used to replace face to face appointments and how rapidly laptops could be provided to enable virtual appointments to keep both patients and staff safe.

53. My team liaised with the Children's Commissioner for Wales and others to produce suitable material for children and young people. I also supported Andrea Grey of Improvement Cymru in the development of adult resources. Following discussions with PHW, it was eventually agreed that their website could be used to provide mental health resources (help and advice) online. This took longer than we would have liked because of the pressure on the PHW website. I recommended the establishment of an expert group to advise and review the material and this was established. This online material was aimed at providing immediate and easy to access to online advice for those who were experiencing lower level mental health issues. It provided practical advice and support but did not provide tailored individual support.

54. The decision on the ability to continue to offer face to face appointments for children and young people were clinical decisions taken by LHBs depending on their circumstances. However, these matters were discussed collectively and

approaches and solutions shared in the weekly meeting. All LHBs worked hard to ensure face to face meetings (including virtual meetings) were available where necessary. Discussions around dementia services also took place in the weekly meetings but again decisions on individual services had to be taken locally by LHBs in the light of the situation on the ground.

55. In May 2020 I produced a business case for developing a prototype or proof of concept for an online tool to support Neurodiverse assessments and support in order to bring neurodiversity services (as well as learning difficulties) under the remit of the MHIG **JJ2BWG01/11-INQ000239519**. Covid-19 added pressure to the provision of services to neurodiverse patients because LHBs' ability to undertake assessment or follow up support to neurodiverse children or children with learning difficulties was severely restricted because they were not best suited to virtual sessions. The tool was intended speed up assessments by allowing the information from various sources to be fed into the tool remotely, thereby cutting out the need for several multi-disciplinary meetings **JJ2BWG01/12-INQ000239522**. Funding was granted on 6 August 2020 **JJ2BWG01/13-INQ000239536**.

56. As part of the Wales Alliance for Mental Health Group I was provided with a copy of the public statement made by the Welsh Government on 21 April 2020 that there was growing evidence that Covid-19 was having a disproportionate impact on the physical health of people with Black, Asian or minority ethnic backgrounds as already exhibited in **JJ2BWG01/01-INQ000239512** and **JJ2BWG01/14-INQ000227107**. Within the Wales Alliance for Mental Health Group it was explained that Welsh Government were considering this paper and the necessary response. I do not recall any discussions or actions required with regard to the mental health of people with Black, Asian or minority ethnic backgrounds.

**Hospital capacity**

57. I was actively involved in monitoring and managing the availability of hospital beds for mental health patients. We kept a very close eye on the number of admissions and discharge, as well as remaining capacity, exhibits **JJ2BWG01/15-INQ000239517** and **JJ2BWG01/16-INQ000239524** refer.

58. The LHBs were doing all they could to release patients early and avoid admissions to manage demand for specialist and non-specialist mental health in-patient beds. However, serious staff shortage as a result of staff members contracting Covid-19 were already having an impact. In addition, where in-patients tested positive for Covid-19 and there was a need to isolate them within suitable in-patient settings this would seriously compromise LHBs' ability to manage within their existing mental health bed capacity.

59. As a result, in April 2020 the MHIG urgently secured a number of mental health and learning disability provider beds from the private sector **JJ2BWG01/17-INQ000239486**.

60. The beds were held nationally on a contingency basis, initially for 90 days with an option to extend for a further 90 days **JJ2BWG01/18-INQ000239488**. Should any LHB require one of the beds they could contact NHS Co-ordinating Centre to gain agreement the arrangements to be made.

61. In order to procure the beds I submitted a business case for funding to the Welsh Government on 24 March 2020 **JJ2BWG01/19-INQ000239489**. On 30 March 2020 an interim amount of £2 million was provided by the Welsh Government via a direct award due to extreme urgency under Regulation 21(2)(c) of the Public Contract Regulations 2015 **JJ2BWG01/20-INQ000239487**.

62. A Ministerial Advice for the project was submitted to the Minister for Health and Social Services on 7 April 2020 and agreed in principle on the same date **JJ2BWG01/21-INQ000136777**.

63. By 2 June 2020, 24 of the surge beds had been used. A decision was taken at a meeting of the MHIG on 1 June to purchase a further 3 beds in order to prepare for any potential second wave **JJ2BWG01/22-INQ000239637** and **JJ2BWG01/23-INQ000239514**. As I recall, approximately 50% of the commissioned beds were used.

64. My role did not involve consideration of the actions taken with regard to care homes, either discharge to care homes or visitation guidance.

**Lessons learned**

65. I believe that the Welsh Government was doing all within its ability to take account of at risk and other vulnerable groups in a very challenging set of circumstance.

66. I cannot comment on the Welsh Government more widely, but I can confirm that the recovery plans for mental health were influenced by a rapid commissioned literature review (an action of the Mental Health Co-ordinating Centre) of the impact of international disasters on mental health as well as research conducted by the voluntary sector and other work commissioned via the 4 nations mental health group. A copy of the rapid evidence assessment of the mental health impacts of large-scale adverse events is exhibited in **JJ2BWG01/24-INQ000338874.**

67. I think, from my experience in mental health services, the Welsh Government's approach over the course of the pandemic did reflect learning from decisions made at earlier stages of its response. In respect of mental health services there were ongoing discussions about how services could be improved, enable better access, and made more resilient etc. as the pandemic developed.

68. I believe the key challenges faced by Welsh Government were in relation to staffing of the response, particularly in the early stages. This was particularly evident in the Health and Social Care Group. Staffing numbers in the Welsh Government in relation to its wide range of functions were tight before the onset of the pandemic. However, I believe that mountains were moved and the close working relationships with both the NHS, Local Authorities and other bodies enabled this to be manageable.

**Statement of Truth**

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

**Signed** Personal Data

**Dated**: 5 December 2023