Module:	2B
Witness Statement:	Jason Christian Graham Killens KAM
Statement No.:	1
Exhibits:	JK/01-JK/48
Dated:	8 December 2023

IN THE UK COVID-19 INQUIRY
Before The Right Honourable
Baroness Heather Hallett D.B.E.

WITNESS STATEMENT OF JASON KILLENS

I, JASON KILLENS, will say as follows: -

Preface

1. The impact of the Covid19 pandemic was felt by our communities; those patients and bereaved families that we responded to, seeking to provide the best care we could in the circumstances; and by the Welsh Ambulance Services NHS Trust ("WAST") as an organisation. We sadly experienced the death in service of four colleagues due to Covid19. This has had an impact on the colleagues of those who have died, and exacerbated the fear and anxiety felt by staff generally in the early stages of the pandemic. The thoughts of everyone at WAST remain with all those impacted by and particularly those families who lost loved ones during the pandemic.

2. Throughout the pandemic WAST staff and volunteers continued to provide excellent care to our patients at a time of fear, anxiety, and considerable change in how we delivered our services. Everyone in our organisation demonstrated a continued commitment to our communities and their colleagues. In response to the pandemic our personnel often worked over and above what we routinely expect from them, and at times when there was little known about the virus and the evolving situation. Our staff worked selflessly and potentially placed themselves, their families and loved ones at risk to continue to provide compassionate, safe, and effective care to patients. I am immensely proud of, and grateful to, all our people for their dedication to public service during such unprecedented times.

Introduction

3. This Statement is prepared in response to a Request for Evidence under Rule 9 of the Inquiry Rules 2006, received from Module 2B of the Inquiry, dated 17 May 2023. The Request has been sent to me in my capacity as Chief Executive Officer ("CEO") for the WAST. It has been requested that I focus on the period 21 January 2020 to 30 May 2022 (I will refer to this as "the specified period").

4. In preparing my statement I have found it helpful to consider the scope of Module 2B as set out by the Inquiry in August 2022. I note the scope is as follows:

> *This module will look at, and make recommendations about, the Welsh Government's core political and administrative decision-making in relation to the Covid-19 pandemic between early January 2020 and May 2022, when the then remaining Covid-19 restrictions were lifted in Wales. It will examine the decision-making of key groups and individuals within the government in Wales including the First Minister and other Welsh Ministers, in particular between early January and late March 2020 when the first national lockdown was imposed.*

A. Background and Qualifications

5. I am the CEO of the Welsh Ambulance Services NHS Trust (WAST), a post I have held since September 2018. Prior to this, I was the CEO of the South Australia Ambulance Service from September 2015 until joining WAST. My ambulance sector career commenced in February 1996 with the London Ambulance Service NHS Trust (LAS) as an operational/frontline Emergency Medical Technician. I concluded twenty years of service with LAS as Executive Director of Operations immediately prior to moving overseas. In nearly three decades of service in three countries/jurisdictions, I have been responsible for ambulance sector response/provision at major planned events such as London's Notting Hill Carnival, Marathon and New Year's Eve celebrations; the London 2012 Olympics and a range of serious and major incidents.

6. As CEO of WAST I am responsible for the safe and effective provision of urgent and emergency ambulance and healthcare services in community and remote settings; non-emergency patient transport and delivery of the national urgent care telephone advice service (NHS 111 Wales). I am also expected to work collaboratively with a wide range of health, emergency service, local, regional and national government and community stakeholders; develop and execute strategies to improve services provided to our communities and the workplace experience for our people and maintain effective

governance mechanisms to safely discharge the functions of WAST. At a formal level, my overall role, functions and responsibilities as CEO remained largely the same throughout the specified period. However, these were heavily influenced by and geared towards WAST's pandemic response and managing the challenges that the pandemic created for us, as will be described in greater detail below.

7. As CEO of WAST, I attend the regular NHS Wales Chief Executives Management Team and Welsh Government Officials Meetings (otherwise known as the Welsh NHS Chief Executives Management Team Meetings or "CEMT") and did so throughout the specified period. I also attend meetings of the Welsh Joint Emergency Services Group ("JESG") and was elected to serve as the Chair of this group from November 2019 to December 2021. As such my term as Chair of the JESG overlapped significantly with the specified period.

B. Overview of relationship with Welsh Government

B.(i). Role and Responsibilities of WAST

8. WAST is the sole national provider of 999 Emergency Medical Services ("EMS") in Wales; provides the call handling and clinical assessment and advice functions of the NHS 111 Wales service; and provides a non-emergency patient transport service ("NEPTS").

9. With regard to the statutory functions of the NHS in Wales including WAST, I would refer the Inquiry to the document prepared and agreed by Welsh Government, the Group of Welsh NHS Bodies and WAST for the purposes of Module 3 of this Inquiry. I exhibit this document as **Exhibit JK/01 – INQ000274845**:

> *The National Health Service in Wales: Agreed description of NHS in Wales between Welsh Government, the Group of Welsh NHS Bodies and the Welsh Ambulance Services NHS Trust.*

10. WAST made a decision early in wave one of the pandemic to focus on our six priority and strategic service areas: ambulance response (EMS, Urgent Care Service and NEPTS); Fleet and 'make ready'; ICT (Information and Communications Technology), including Health Informatics; supply chain; resource centres; and Clinical Contact Centres (inclusive of NHS Direct Wales, 111 and NEPTS control). This meant that some corporate staff were retrained and redeployed to these mission critical areas and to the

pandemic response. Recruitment continued to support organisational growth as did associated training, with much of that training delivered virtually.

EMS

11. WAST currently manages between 1,000 and 2,000 emergency calls a day across Wales, and every year takes in the region of half a million emergency calls for 445,000 to 480,000 incidents (where a response to scene takes place) in the three Clinical Contact Centres in Wales. It provides a number of responses, including: traditional double crewed emergency ambulances; solo car responders; urgent care vehicles; volunteer first responders; specialist teams; and even paramedics on bicycles or on foot in some cities. In total, WAST has over 300 emergency vehicles based in 90 ambulance stations across Wales. In addition, Clinicians based at these Clinical Call Centres can offer remote clinical assessments, advice and onward referral over the phone. Since December 2022, these activities may be supported using video technology.

12. During wave one of the pandemic WAST's experience was that the demand for EMS and NEPTS reduced whilst NHS 111 Wales demand increased significantly. However, demand increased for EMS and again for 111 during the second and third waves and has remained high, with NEPTS activity now returning to largely pre-pandemic levels.

111 Service

13. WAST provides the call handling and clinical assessment and advice functions to around 1,000,000 callers per year as part of NHS 111 Wales ("111 Service"). Non-clinical call handling staff record details from callers and provide triage and advice supported by decision support software. If required, a nurse, paramedic or dental advisor will remotely assess the patient's medical issue and provide a resolution or refer the caller to another pathway which meets their needs. In the out-of-hours period this referral is most often to the relevant Welsh Health Boards' GP out-of-hours service. The service also has a team of Health Information Advisors who provide other non-clinical advice for callers.

14. During the pandemic, the NHS 111 Wales Service experienced significant peaks and sustained increases in activity both in and out-of-hours. I understand that the exceptional demand experienced by WAST in this respect was in line with the experience of providers across the UK. Significant agility was required to respond to this increased demand, particularly given the initial lack of evidence to inform call takers' prioritisation of calls and clinical decision making.

15. Four of the seven Health Boards had transitioned from NHS Direct Wales to the NHS 111 Wales Service prior to the pandemic. The NHS 111 Wales Service is a free of charge call, whereas the NHS Direct Wales 0845 number was chargeable. In the first wave the NHS 111 Wales Service was made available nationally in all Health Board regions for Covid-19 questions so everyone could avail themselves of the free call and centralised advice. The three remaining Health Boards made the full transition to the NHS 111 Wales Service during the pandemic which also contributed to the increased demand as they were regions of high-density populations.

16. To respond to the increasing demand WAST required additional staff, which involved the recruitment of new staff and redeployment of staff from corporate services to almost double call handler capacity. The method of redeployment was refined during the three waves of the pandemic to ensure the balance was appropriate. The 111 Service estate was also quickly expanded (to incorporate social distancing requirements and additional personnel) and WAST introduced a new and quicker front line triage process enabling higher volumes to be managed within existing capacity and improved call handling technology utilising numeric options on call connection, to signpost callers quickly to the pathway they needed. Staff who were able to work from home were provided with equipment to enable this and the Trust rapidly embraced the roll out of Microsoft 365 which facilitated a smoother transition to virtual working.

17. An entirely new sick note function was introduced to the 111 service during the early stages of the pandemic, enabling members of the public to provide their employers with necessary certification when this was required. A web-based symptom checker for Covid-19 allowed callers to check their symptoms and receive self-care advice to avoid the need to contact 111 or another healthcare provider via phone. Additionally, where appropriate the symptom checker issued a self-isolation sick note for all those who qualified, again reducing telephony demand on 111 and the wider urgent care system.

18. The NHS 111 Wales website received more than 350,000 visits per week in the first few weeks of the pandemic.

Non-Emergency Patient Transport Service (NEPTS)

19. NEPTS provides transport to patients for planned journeys to and from treatment facilities and clinics, across Wales. In 2019, the service completed more than 650,000

journeys using different modes of transport ranging from taxis, volunteers, to non-emergency ambulance transport vehicles.

20. From the beginning of the pandemic, the service saw a significant drop in activity as a result of reductions in the volume of planned care and outpatient appointments delivered by Health Boards. However, fewer patients were able to be transported per vehicle because of social distancing requirements.

Mobile Testing Units

21. Across September and October 2020 WAST deployed four Welsh Surge Test Trace Protect ("TTP") Mobile Testing Units, mobilising a predominantly temporary workforce to provide community-based PCR and later, some Lateral Flow Testing (LFT). This service provision continued through to the end of March 2023. This was a service that was commissioned by the Welsh Department of Health and Social Care in conjunction with Test, Trace and Protect. I understand that it was considered to be necessary to supplement community testing facilities that may not have been readily available or to provide surge testing capacity. WAST did not propose or initiate the idea, but we were aware of the desire on the part of Test, Trace and Protect to provide mobile testing across the communities. WAST is an organisation with expertise in clinical logistics, access to a fleet of vehicles, national infrastructure and experience of providing mobile services in communities. We were also able to recruit people to staff the service and had the leadership capacity and capability to provide it. As such, we considered ourselves to be well placed to provide this service and we offered to step up and provide it. This offer was accepted. We costed up the project, received funding from the Department for Health and Social Care ("DHSC") at a UK Government level to cover the costs (whilst we did have a relationship with Welsh Government to establish the value and route of funding flow, the resources came from DHSC UK), and began to provide the service.

22. Units have been deployed at different locations across Wales to complement static testing sites. The locations for testing were determined by Health Boards in collaboration with the Welsh TTP service. Members of the public have been directed to these units following contact with the TTP service. Since deployment began the units have seen almost 75,000 PCR tests and more than 1,000 LFT tests completed. This was an entirely new role for WAST that we stepped into and mobilised during the pandemic.

23. I have been asked whether there has been any evaluation of this service. Throughout the provision of the service, we were constantly evaluating how it was operating on an

informal basis and through feedback. This process allowed us to consider whether and how our provision of the service could be improved by constant evolution and adaptation. WAST did not conduct a formal evaluation of the service, our role was as a commissioned service provider as such it would not ordinarily be for us to conduct such a formal evaluation.

B.(ii). Interactions and Meetings with Welsh Government

24. I have been asked to provide an overview of the interactions between WAST and the Welsh Government, including any regular meetings that were in place prior to the pandemic.

NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting

25. The primary touchpoint between WAST and the Welsh Government was the NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting, referred to above. These meetings took place with increasing frequency as the pandemic progressed, often occurring every other day.

26. These meetings were arranged by Dr Andrew Goodall, the Director General Health and Social Services/NHS Wales Chief Executive in order to share information with the CEOs of the Welsh Health Bodies and to allow Dr Goodall to take on strategic issues on our behalf (as explained by Dr Goodall at sub-paragraph 3 page 1 of **Exhibit JK/02 – INQ000274846**) The meetings largely took place over Skype and latterly MS Teams and were attended by the Chief Executives of the seven Welsh Local Health Boards, the three NHS Trusts, Health Education and Improvement Wales and Digital Health and Care Wales and by Welsh Government Officials including Dr Goodall.

27. As CEO of WAST, I was in attendance at these meetings. I exhibit to this statement a schedule of such meetings that took place in the specified period, with the WAST attendees indicated. (**Exhibit** **JK/3.1 INQ000336089**). To further assist the Inquiry, along with this witness statement I also provide general disclosure of the summary notes of each of these meetings.
JK/3.2 INQ000336090 **JK/3.3 INQ000336091**

NHS Wales Executive Leadership Board

28. I or my deputies as necessary also represented WAST at the monthly meetings of the NHS Wales Executive Leadership Board. The role of this board as set out in its terms of reference (**Exhibit JK/04 - INQ000274974**) is to provide executive leadership, direction

and oversight of the performance, delivery, quality and safety of NHS services, workforce and functions in Wales. The terms of reference go on to state that one of the key functions of this board is:

> *To provide a forum for NHS Wales to contribute to the development of Welsh Government strategy, policy and legislation proposals and discuss an NHS Wales (executive) response to formal consultations. Subsequent formal collective responses will be brokered by NHS Confederation and agreed with individual Boards.*

29. The Board membership includes the Chief Executives of the Welsh NHS Bodies and the Chief Executive of NHS Wales, Dr Andrew Goodall. During the specified period Board meeting attendees also included the Chief Medical Officer, Sir Frank Atherton. I exhibit to this statement a schedule of Board meetings that took place in the specified period, with the WAST attendees indicated as **Exhibit JK/05** **INQ000274176**. To further assist the Inquiry, along with this witness statement I also provide general disclosure of the minutes of these meetings.

Joint Emergency Services Group (JESG) Wales

30. As part of my role as CEO of WAST, I also attended meetings of the JESG. This is a non-statutory collaborative body which brings together all of the emergency services in Wales, NHS Wales, the Welsh Government and the armed forces at the most senior level to consider how to take forward their contribution to civil contingencies and counterterrorism in Wales as well as addressing wider cross-service issues of joint interest. I exhibit the May 2019 Terms of Reference for the JESG as **Exhibit JK/06 - INQ000275026**.

31. In November 2019 I was elected chair of the JESG. The previous chair had been the Chief Constable of South Wales Police, and this was the first occasion on which an ambulance service CEO had chaired the group. I served a fixed term of two years as Chair until December 2021, a term that largely overlaps with the specified period.

32. Meetings of the JESG were attended by representatives of the Welsh Government including Dr Andrew Goodall, Director General Health and Social Services Group and Chief Executive of NHS Wales; Mr Reg Kilpatrick, Director General Covid-19 and Director Local Government; Ms Karin Phillips; Ms Ffion Thomas and Mr Garry Haggarty.

33. Under its Terms of Reference the JESG was intended to meet three times per year with additional meetings being called in exceptional circumstances. However, as a result of the pandemic over the course of the specified period, the JESG met on 49 occasions, with 48 of those meetings taking place virtually. I exhibit to this statement a schedule of these meetings of the JESG including the dates and indicating the attendees from WAST, **Exhibit JK/07 - INQ000275027**. To further assist the Inquiry, along with this witness statement I also provide general disclosure of the minutes of these meetings.

34. These meetings provided an opportunity to discuss and provide updates on the operational pressures facing WAST throughout the pandemic (see for example the meetings of 4 December 2020, 18 December 2020, and 23 July 2021) and to coordinate and cooperate with other emergency services (see for example the meetings of 17 December 2021 and 21 January 2022 the minutes of which are exhibited as **Exhibit JK/24 - INQ000335969** and **Exhibit JK/25 – INQ000335970** respectively) in a forum that included representatives of the Government. As such, while the JESG does not occupy a formal role in the decision making or command and response structures, nor is it a decision-making committee, the meetings, however, provided a pathway by which operational and other pressures could be flagged to the Government and thereby some influence may have been exerted on decision making in this way.

35. The JESG produced a Report entitled "Joint Emergency Services Group (JESG) Wales, Covid March 2020 – June 2022 Report", dated 6 December 2022, which is exhibited to this statement as **Exhibit JK/08 - INQ000275078**. The Report sets out an overview of JESG activities during the Pandemic and lessons identified.

Correspondence

36. Additionally, I had direct contact with Dr Andrew Goodall and his office via letters, email and text messaging. I exhibit the letters and emails to this statement as **Exhibit JK/09.1-JK/09.20 - INQ000361352; INQ000361359; INQ000361369; INQ000361370; INQ000361375; INQ000361372; INQ000361377; INQ000361357; INQ000361368; INQ000361363; INQ000361358; INQ000361373; INQ000361378; INQ000361362; INQ000361371; INQ000361374; INQ000361361; INQ000361353; INQ000361354; INQ000361355**. The text messages are exhibited below at §85(a).

C. Initial Response to the Pandemic January – March 2020

37. I first became aware of COVID-19 through international reports about the situation in China in early January 2020. On 21 January 2020, WAST's Medical Director, Dr

Brendan Lloyd, attended on my behalf a meeting of the NHS Wales Executive Board that was chaired by Dr Andrew Goodall. At this meeting an update was provided on the "Wuhan Coronavirus" as it was then called. It was stated that 279 cases had been reported with 6 deaths, the threat to the UK had moved from very low to low and an incident group had been set up. The Chief Medical Officer, Sir Frank Atherton, stated that colleagues needed to think about their plans for isolation and ambulances if the virus did come to the UK (See: **Exhibit JK/10 - INQ000275091**).

38. On 28 January 2020 local guidelines were issued by WAST for the management of potential COVID contacts accessing NHSDW/111 (See: **Exhibit JK/11 - INQ000275092**. This guidance was informed by the advice provided by Public Health Wales. These local guidelines were dynamically updated throughout the pandemic **(Exhibit JK/12.1 – JK/12.28 - INQ000275093; INQ000275094; INQ000275095; INQ000275096; INQ000275097; INQ000275098; INQ000275099; INQ000275100; INQ000275101; INQ000275102; INQ000275103; INQ000275104; INQ000275105; INQ000275106; INQ000275107; INQ000275108; INQ000275109; INQ000275110; INQ000275111; INQ000275112; INQ000275113; INQ000275114; INQ000275115; INQ000275116; INQ000275117; INQ000275118; INQ000275119; INQ000275120)**. I also exhibit the Supplementary Guidance for the Management of Possible Cases of Corona Virus that was issued on 24 January 2020 (*see:* **Exhibit JK/13 – INQ000275121**); and the WAST Standard Operating Procedure for Dealing with Suspected Wuhan Corona Virus, issued on 20 January 2020. (see: **Exhibit JK/14 – INQ000275122***)*. Our guidance documents and approach at this stage were informed by regular advice and information received from Public Health Wales, an example of which is exhibited to the witness statement as **Exhibit JK/15 – INQ000275123**.

39. WAST had an existing plan for the management of a pandemic influenza outbreak in place at this time, which had been subject to regular review. On 4 February 2020 a pandemic tabletop exercise was initiated to review plans and capacity. As a result of this the WAST Executive team took the view that it was appropriate to informally trigger the existing pandemic influenza plan and, in so doing, enable the establishment of a clear operational response structure charged with the rapid development of the organisation's pandemic delivery plans. Until early March, while extensive planning was undertaken, the informal status of the plan remained. However, the potential impact of Covid-19 on Wales was becoming increasingly obvious and, on 4 March 2020, I, with the support of the Executive Team and the Board, formally triggered the arrangements within the pandemic influenza plan, approving the organisation's pandemic strategy.

40. On 3 March 2020 I had a telephone call with Dr Andrew Goodall concerning COVID 19 and the NHS planning and response, this was followed with a national conference call in which Dr Goodall spoke with me and the Chief Executives of the Welsh health bodies on 4 March 2020. On 5 March 2020, Dr Goodall wrote to the participants on that conference call setting out the next steps in the pandemic response planning **(see: Exhibit JK/02 – INQ000274846).**

41. Following this letter there were frequent and regular NHS Wales Chief Executives Management Team and Welsh Government Officials Meetings see **Exhibit JK/3.1 INQ000336089** as referred to above. In terms of the period between January 2020 and March 2020 there were three such meetings: 25 March 2020, 27 March 2020 and 30 March 2020. In terms of the information sought by the Welsh Government in these early meetings, on 27 March 2020 the Local Health Boards were requested to submit projections on PPE usage.

42. In my experience, the Welsh Government did, in the early stages of the pandemic (January 2020 to March 2020), recognise the gravity of what we were facing and enabled all organisations to respond. Dialogue between WAST and the Welsh Government was frequent as is demonstrated by the schedules of meetings and informal communications exhibited above. Furthermore, my sense was that any information that the Government had was being freely shared with us. I did not consider that anything was being held back.

43. I am asked for my views on the initial lockdown in March 2020. It is important to draw the distinction that this was a UK intervention and not a Welsh Government intervention. In my view, it was necessary and the right thing to do. We did not have a choice, given that we were seeing the widespread effects of Covid-19 in the community, so it was necessary to have some control mechanisms. The context needs to be borne in mind, including the prevalence of Covid-19 in the community, the fact that there were no treatments and no vaccines available, and no real understanding of the spread of Covid-19 and how it could be controlled. We did know, however, that people getting seriously ill with Covid-19 had a 50% chance of dying once they were sufficiently seriously ill to require admittance to an Intensive Care Unit. For WAST, the lockdown was about slowing the spread of Covid-19, reducing demand as a result of non-pharmaceutical

infection control and reduction and minimising the risk of harm to our workforce. My personal view is that it was obvious that such a course of action would become necessary, in the circumstances at the time, a number of weeks prior to when the lockdown was actually announced.

44. I do not recall the Welsh Government approaching me for any advice regarding their initial understanding and proposed management of Covid-19 in Wales during the period January to March 2020.

45. I have been asked for my comments regarding the decisions of the Welsh Government in respect of international travel and border control during the early stages of the pandemic. At the outset, I should note that the main ports of entry to the UK are largely outside of Wales. There is one international airport in Wales (Cardiff) – with a small number of international flights – and a number of ferry ports. The main airports that would serve Wales are Bristol, London, Birmingham, Liverpool, and Manchester. As such, this was largely a UK Government issue. In my view, the decisions taken by the UK Government in this regard lacked sufficient pace and focus, given that it was obvious at the time that early and decisive controls around international travel could have been helpful in further controlling the spread of the virus.

46. I have been asked to comment on the extent to which core decisions taken by the Welsh Government in response to the Pandemic during the period January to March 2020 aligned with those of the UK Government. During that period, my understanding is that the Welsh Government were essentially mirroring what was happening in Westminster. I consider that this approach of alignment was helpful in the early stages for consistency for the public in supporting their compliance with the measures in place. I do not consider that the Welsh Government should have made more decisions autonomously, as it was helpful for Wales to remain aligned with the UK Government decision-making at that time. I do not feel that I am appropriately placed to answer the question as to whether the Welsh Government was curtailed or assisted by the decisions of the UK Government during this stage of the pandemic.

D. Engagement with the Welsh Government over the course of the Covid-19 Pandemic

47. WAST had no role in any core decisions taken by the Welsh Government over the course of the Covid-19 Pandemic. However, I would add that, in my capacity as Chair of JESG from November 2019 to December 2021, whilst JESG had no formal role in

Welsh Government decision-making, it is possible that the discussions during the JESG meetings may have informed Welsh Government decision-making to some extent, although this is impossible for me to say with any certainty. I speculate that the JESG discussions *may* have informed Welsh Government decision making because these meetings were regularly attended by Dr Andrew Goodall, the Director General for Health. They were also attended by Reg Kilpatrick, who held the role of Director General for Covid Response. On occasions, they would have indicated to the group potential actions that the Government were minded to take and ask for our views or input. An example can be seen in the minutes of the JESG meeting 17 July 2020 where facemasks and local lockdowns were discussed (**Exhibit JK/48 – INQ000335994)**. Both Dr Goodall and Mr Kilpatrick would have had regularly attended Welsh Cabinet meetings and so they may have drawn on their knowledge of discussions at JESG meetings when advising the Government. I am confident that Dr Goodall and Mr Kilpatrick would at least have relayed the views of the JESG as a group to Cabinet. However, it is impossible for me to say whether this would have had an influence on any specific decisions made by the Welsh Government as I was not privy to cabinet deliberations.

48. Save for the below, I was not involved in the preparation and/or provision of advice to the Welsh Government regarding its proposed or actual management of the pandemic.

49. The only occasion where I arguably gave formal advice to the Welsh Government was in respect of WAST's request for sign-off of military aid. I provided professional advice to Dr Andrew Goodall that the military aid was required in the form of 250 soldiers to allow us to put more ambulances out. My advice was followed in respect of this request. Much of this advice was given in discussions over the telephone, however some was provided in my formal accountable officer correspondence with Dr Goodall (see the Letter Re: WAST Planning and Response to COVID 19 dated 1 May 2020 and the appendices thereto, exhibited to this statement as **Exhibit JK/16.1 – JK/16.6 – INQ000361386; INQ000361380; INQ000361358; INQ000361372; INQ000361373; INQ000361378**). Further communication on this matter took place via email correspondence, which I exhibit to this witness statement as **Exhibit JK/17.1 – JK/17.3 comprising: INQ000275130; INQ000275131; and INQ000275132.**

50. We did, of course, provide the Welsh Government with information commenting upon ambulance capacity and what resources we needed bearing in mind the modelling we had available (see my Accountable Officer Letters to Dr Andrew Goodall: **Exhibit JK/18.1 – JK/18.4 comprising: INQ000361392, INQ000361389, INQ000361390 INQ000361391** and the minutes of the NHS Wales Chief Executives Management

Team and Welsh Government Officials Meetings). This was not provided in the context of requesting permission to take steps, as the ambulance service response in Wales was managed solely by WAST and through ensuring key relevant stakeholders such as members of the Emergency Ambulance Services Committee (EASC) who act as our commissioners were regularly appraised of our plans and actions. We also provided data to the Welsh Government regarding trends, including cases involving difficulty in breathing, 111 and 999 data. In the early stages of the pandemic this data would feed into and enable assessments of the prevalence and distribution of Covid cases. The data also could be used to draw inferences regarding waves of the Pandemic. For example, we would see cases involving breathing issues increase 10-14 days prior to the onset of a wave being seen through community testing our hospital in-patient numbers. The data was therefore a valuable indicator of a rising prevalence of Covid-19 in the community. However, I would not consider this to have been formal advice. As the pandemic progressed, this data also informed modelling for the expected service demand.

51. I have been asked to provide a chronology of any decision-making committees, groups or forums dealing with or impacting upon the Welsh Government's response to Covid-19 which I attended and/or provided advice or briefings to during the specified period. The primary such committee to which I contributed was the NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting described at §25-§27 above and a chronology of the meetings of which is exhibited at §27 above as **Exhibit JK/03 - INQ000274847**.

52. In terms of the role I played on each occasion I attended these meetings, for the most part I took part in the general discussions and deliberations as recorded in the minutes that I have provided as general disclosure. I represented WAST, provided updates regarding capacity, demand, pressures and other such information as necessary. Over and above this:

    a. On 1 April 2020 I provided the meeting with an update on WAST staffing, 111 and 999 capacity and new call centres (**Exhibit JK/26 – INQ000335971)**.

    b. On 6 April 2020 I was requested by Andrew Goodall to provide WAST information for an upcoming press conference (**Exhibit JK/27 – INQ000335972)**.

    c. On 13 July 2020 I updated the meeting that WAST was seeing an increase in patient handover delays at hospital emergency departments. I outlined that

demand and capacity were not yet fully understood and a robust system was required before winter. I expressed the view that the alternatives developed to access services during Covid should be maintained (**Exhibit JK/28 – INQ000335973)**.

d. On 17 July 2020 there was a discussion regarding preparation for winter and updating systems so that data on the activity emerging from the community could be captured to help the prediction of any surges in Covid (**Exhibit JK/29 – INQ000335974)**.

e. On 2 November 2020 I updated the meeting that WAST was recruiting national call centre employees and that a phased approach was being taken (**Exhibit JK/30 – INQ000335975)**.

f. On 30 November 2020 I informed the meeting that 12% of 111 calls were Covid related and that WAST was experiencing staffing issues due to self-isolation (**Exhibit JK/31 – INQ000335976)**.

g. On 4 December 2020 I provided an update on staff recruitment and working hours that were being lost to Covid. I also provided information regarding a Critical Incident had been declared due to pressures on WAST response times the previous day (**Exhibit JK/32 – INQ000335977)**.

h. On 4 January 2021 I provided an update on the status and capacity of WAST services, staffing issues and support that was being provided from the MOD. I also set out that WAST were providing 999 call handling support to London as were other Trusts around the UK (**Exhibit JK/33 – INQ000335978)**.

i. On 5 January 2021 I provided an update on the process of vaccinating WAST staff (**Exhibit JK/34 – INQ000335979)**.

j. On 8 March 2021 I informed the meeting that WAST was stepping down military support (**Exhibit JK/35 – INQ000335980)**.

k. On 26 July 2021 I described to the meeting the substantial pressure that was on the pre-hospital space. Demand management plans were up to level 6 on several days the previous week, meaning that WAST was only responding to Red or Amber level 1 requests. I expressed concern about the need to unlock the backlog in emergency departments (**Exhibit JK/36 – INQ000335981)**.

l. On 1 November 2021 I informed the meeting that WAST had experienced the worst week ever for patient handover at hospital emergency departments and updated on the use of military assistance (**Exhibit JK/37 – INQ000335982)**.

m. On 30 December 2021 I informed the meeting that Covid related absences were increasing and that this was affecting field operations by 10%. There was an indication of increasing 111 calls (**Exhibit JK/38 – INQ000335983)**.

n. On 4 January 2022 I informed the meeting that WAST had received the highest level of Covid related 999 calls and increases in 111 calls. There was at that point very long ambulance waits in the community (**Exhibit JK/39 – INQ000335984)**.

o. On 31 January 2022 the meeting was informed that WAST had returned to level 1 in relation to Protocol 36[1] having seen a reduction in Covid related calls (**Exhibit JK/40 – INQ000335985)**.

p. On 7 February 2022 I informed the meeting that 25% of WAST's capacity in January had been lost due to patient handover delays at emergency departments and that in February the data was looking similar, which was creating an untenable situation. The imminent end of military assistance at the end of March was likely to create further pressure (**Exhibit JK/41 – INQ000335987)**.

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[1] Protocol 36 *was a triage system that was designed specifically to assist managing an increase in calls during a pandemic by identifying those patients with COVID symptoms quickly and modifying the response. Protocol 36 encompasses three protocols (06 Breathing Problems, 10 Chest Pain and 26, Sick Person) and includes additional questions to identify those patients suspected of having COVID symptoms. There are four levels of triage in Protocol 36 ranging from zero to three. Level zero is the surveillance level where there are no changes to any of the determinant code responses. For example, at level two a caller who is identified as non-cardiac chest with COVID symptoms would receive a modified response which might include a change in response priority (Amber 2 instead of Amber 1) or a clinical telephone assessment. At level one patients identified with non-priority symptoms (but positive for COVID symptoms) would have a modified response such as secondary telephone assessment by a clinician, referral to a healthcare professional or a different level of response.*

q. On 3 May 2022 I reported that WAST had had an improved week with indications being more positive and staff absences much lower (**Exhibit JK/42 – INQ000335988)**.

53. I consider that Welsh Government had sufficient meetings and interaction with WAST over the course of the pandemic. An example of positive collaboration between WAST and Welsh Government was, as explained above, our requests for military aid, which were agreed. For the Inquiry's information, the various requests for Military Aid to the Civil Authorities ("MACA") made by WAST over the course of the pandemic are exhibited to this Statement as **Exhibit JK/19.1 – JK/19.8 comprising: INQ000257139; INQ000275140; INQ000275141; INQ000275142; INQ000257143; INQ000275144; INQ000275145; and INQ000275146.** The relevance of documents **INQ000275144** and **INQ000275145** is that the reference to the inclusion of "partners" to increase capacity relates to, *inter alia,* the use of military personnel as drivers for WAST, as is explained in the 'keys' in those documents.

54. WAST was not part of the Technical Advisory Group ("TAG") and had no involvement with that group or its sub-groups.

55. At the beginning of the pandemic the Welsh Government Health and Social Services Group set up a Planning and Response Group to provide a strategic forum for Wales' health and social care planning and response to the pandemic and the associated risks. The terms of reference of this Planning and Response Group are exhibited to this witness statement as **Exhibit JK/20 – INQ000275147**. This group was attended by the Head of Resilience on behalf of WAST and also was attended by a representative of the Technical Advisory Cell.

56. As referred to above, throughout the pandemic, WAST shared data and statistics with the Welsh Government both formally and informally in a number of different formats and via a number of different routes. The regular NHS Wales Chief Executives Management Team and Welsh Government Officials Meetings was one such route as described above. I would have also provided such information to Dr Andrew Goodall via my Accountable Officer Letters exhibited at §50 above as **Exhibit JK/18.1 – JK/18.4 comprising: INQ000275135; INQ000275136; INQ000275137; and INQ000275138**. I confirm that these were all of the Accountable Officer Letters that I sent to Andrew Goodall during the Specified Period. In my experience, I would ordinarily consider this to be a large number of Accountable Officer Letters to be sent over this timespan. This perhaps reflects the extraordinary context in which we were operating at the time.

Further information would also have been provided through my correspondence and informal communications with Dr Goodall as already exhibited to this witness statement. WAST's Medical Director, Dr Brendan Lloyd would also have shared data with the Chief Medical Officer and would have relayed the clinical picture that we were seeing. In my view this combination of formal and informal data sharing worked well. It helped to create a picture of the pressures that everyone was under and with what we had at the time it was the best that we could muster. I cannot identify any challenges with the mechanism of data sharing.

57. I am asked whether WAST had sufficient access to Wales-specific modelling over the course of the pandemic to inform its response. Whilst operational and future wave scenario modelling was available as the pandemic progressed, this was focused on acute healthcare settings. Thus, there was no ambulance or community specific modelling provided other than for predicted case prevalence. Throughout the pandemic, whilst the 'R' rate was provided, service impact modelling was focussed on the rates for hospital admission and rates of those likely to require critical levels of hospital care.

58. The primary area in which modelling data would have been helpful to WAST related to how the community transmission rate could be expected to impact on the level of 999 or 111 calls. This was the area that would have most impact on WAST from a service delivery perspective. Given our role, modelling relating to the demand on ITU beds etc would have been of less immediate operational relevance to us. However, there was no government or scientific creation of modelling to indicate to WAST the rates of community transmission that may lead to calling either 111 or 999. We had to retrofit the existing modelling to meet our purposes, making a number of assumptions as to how this would translate to our setting.

59. The first batch of this 'retrofitted' forecasting and modelling was undertaken with Operational Research in Health Ltd (ORH), with initial results being made available on 1 April 2020. It is, therefore, correct to say that we did not have access to modelling to indicate the expected impact of community transmission rates on the demand on our 999 or 111 services until that date. The forecasting and modelling updated the incident demand profile used in the 2019 EMS Demand & Capacity Review with observed demand data from March 2020, to reflect the changing acuity mix of the patient demand and increase in demand. These changes were not driven by the pandemic. ORH then used Covid daily number of new infection rates to further increase the patient demand to reflect the forecast waves of Covid based on three scenarios; a 75% social distancing compliance, a 50% social distancing compliance and a 25% social distancing

compliance. The modelling also included reductions in ambulance unit hours production to take account of the impact of Covid on sickness absence in the Trust's frontline workforce and a modelled level of hospital handover based on reduced handover being observed in the early part of the pandemic, but also reflecting the forecast increase in conveyance of patients linked to the pandemic.

60. The first batch of forecasting and modelling estimated a 21.7% point fall in Red 8 (immediately life threatening) minute performance to 53.6% in "week 15", which was the next week, with "week 15" terminology being drawn from the Covid-19 forecasts. The modelling also estimated very long Amber 1 (serious, but not immediately life threatening) waits of 413 minutes (our ideal response time for this group of patients is 18 minutes). It was agreed with the Executive Director of Operations to model what resources would be required to deliver an acceptable level of Amber 1 performance (30 minutes being a close reflection of preceding months' median performance). This modelling identified that the Trust would need an extra 1,512 emergency ambulance unit hours per week on top of the 17,296 planned emergency ambulance unit hours per week. It should be noted that the 17,296 is 100% of the plan and the reality for the Trust is that a lower unit hours production was being delivered pre-pandemic because of a "relief gap" i.e. the gap between the number of full-time staff required for the rosters versus the budgeted establishment, for example it was 90% in March 2020.

61. One of my key priorities was to focus on the recruitment of staff into the front-line EMS and close the relief gap over a two-year period, linked to funding provided by the EASC. In the short term the Trust sought to boost ambulance production through tactical responses e.g. overtime, bank staff, and mutual aid to civil authorities from the military.

62. The recruitment to close the "relief gap" formed part of wider recommendations by the 2019 EMS Demand & Capacity Review by ORH, so from the 29 May 2020 a formal programme of transformation projects was constituted: the EMS Demand & Capacity Review, which has met every three weeks subsequently and has delivered the uplift in staff to close the "relief gap", increased the number and proportion of incidents resolved through remote clinical assessment without sending a mobile ambulance resource (consult & close rates), and a demand led pan-Wales re-roster of every EMS station.

63. On reflection, another area in which modelling data may have been useful to WAST was the expected impact of the community transmission rate on our workforce and the rate of Covid-related absences among front-line, community-based healthcare workers such as ambulance staff. In fact, we adopted an iterative approach to this, based initially on

an assumed Covid-related staff absence rate of between 20-30%, as set out in our pandemic flu plan. As the pandemic went on, we refined these assumptions based on community transmission. Ultimately, we never reached an absence rate of 30% so the absence of modelling in this area did not have a negative impact on our operations. However, a more scientific modelling-based approach to planning for such contingencies may have been of assistance.

64. I am asked to explain the mechanisms by which WAST was able to ask questions of the Welsh Government about scientific advice, data, statistics and modelling to ensure that it could effectively coordinate its response to the pandemic. The Chief Scientific Advisor, Dr Rob Offord from Public Health Wales, would periodically attend some of the NHS Wales Chief Executives Management Team and Welsh Government Officials Meetings and would unpack what the modelling was saying. I consider that there was sufficient opportunity for us to ask such questions. It was just that the available modelling itself was deficient for WAST's purposes.

E. NPIs

65. Information and data were being provided by WAST to Welsh Government as set out above. WAST had no formal role in advising Welsh Government in respect of NPIs.

66. The only other way in which influence might have been successful is that Dr Andrew Goodall, the Director General, was frequently attending upon the Welsh Cabinet. As set out above, the CEOs of the Welsh Health Bodies including me were sharing with Dr Andrew Goodall, in those regular weekly or bi-weekly calls, the operational context. That would very likely then have been communicated by him to Welsh Government Ministers. It is therefore likely that this operational context was a feature of some of the decisions made by Welsh Government during the Pandemic, and that Ministers may have been swayed by this, however, this is no more than informed assumption on my part.

67. There were certain times when, in my view, Wales held a stricter line than England in terms of NPIs. By this I mean that there were times when Wales had stricter geographical restrictions than those that were in place in England. To my recollection, Wales had certain NPIs such as the 'rule of six' in place for longer than England. As I live in England and work in Wales, I was travelling between the two jurisdictions at the time, and I recall that there were differences in the timings of the lifting of lockdowns with Wales being later to ease the lockdowns. Obviously, as the pandemic went on there were variations in geographical NPIs as dictated by the regional R rate. However, it was

my view at the time, and it remains my view, that compared to the approach taken in England, Wales appeared to be seeking to drive the community transition rate lower before the NPIs were released. It may have been that Dr Andrew Goodall's communication to the Welsh Government of the pressure that was on the NHS had an influence in this. I am unable to say whether this was in fact the case.

68. I am asked to identify any key meetings between the Welsh Government and representatives of WAST where NPIs were discussed. At the NHS Wales Chief Executives Management Team and Welsh Government Officials Meetings NPIs were often spoken about in terms of the impact they were having and the acceptance of them by the population. As set out above, I would have attended these meetings along with the Chief Executives of the other Welsh Health Bodies and Andrew Goodall.

    a. At the NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting on 22 May 2020 it was noted that there were concerns about the easing of the lockdown in England and the public behaviour of non-compliance. It was also noted that areas of the Welsh Valleys were ignoring lockdown messages and there was a belief that the community had already been affected by the virus before Christmas and was immune (**Exhibit JK/43 – INQ000335989)**.

    b. At the NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting on 27 May 2020, it was noted that the Welsh population was continuing to comply with the regulations and that public trust needed to be maintained in this regard (**Exhibit JK/44 – INQ000335990)**.

    c. At the NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting on 29 May 2020 it was noted that in Wales there was a strong public acceptance for the need for lockdown measures and anxieties about people coming to Wales (**Exhibit JK/45 – INQ000335991)**.

    d. On 5 June 2020 there was discussion at the NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting about the challenges that social distancing guidance was posing to the workforce (**Exhibit JK/46 – INQ000335992)**.

    e. On 15 June 2020 it was noted at the NHS Wales Chief Executives Management Team and Welsh Government Officials Meeting that there were a variety of considerations that the Chief Medical Officers were discussing about mitigation

and levels of risk in relation to the one or two metre rule (**Exhibit JK/47 – INQ000335993)**.

69. I am asked to explain, in terms of the decisions made about NPIs, whether I or representatives of WAST advised the Welsh Government on, or in providing our advice, had regard to different groups of people including the vulnerable and those at risk, and those with protected characteristics under the Equality Act 2010. As should be clear from the above, neither I nor other WAST representatives, strictly speaking advised the Welsh Government on decisions made about NPIs. Discussions of NPIs may have included consideration of issues arising from shielding such as the delivery of meals to certain clinically vulnerable patients for example. However, beyond that, WAST would not have had any significant involvement in the identification and consideration of at risk and other clinically vulnerable persons, the assessment of how NPIs would impact different groups or the assessment of how NPIs would impact on existing inequalities in Wales.

70. I was of the view that as the suite of non-pharmaceutical interventions became increasingly complex and were frequently changing, the public messaging from Welsh Government needed to change so that the message was cleaner, crisper and simpler so that it was not so hard for people to understand what they needed to do. For example, the simplicity of the message – "stay at home" – worked well because it was clear and simple.

71. I think that the daily press conferences worked well as there was a regular sharing of the rationale for why decisions were being made. This made it real for people and people could make their own informed decisions based on the information that they were receiving. I believe that the early clarity of messaging and regular communication in a style that connected with communities aided better compliance.

72. Coordination between WAST and the Welsh Government was largely good. However, advance notice regarding changes to Welsh Government policy/rules would have been helpful. Instead, in the very early stages of the pandemic we found out at the same time as the rest of the public did, and latterly perhaps at best an hour beforehand. However, equally I recognise that there are factors weighing against this, for example the high risk of information leaking to the media. Advance notice, particularly about lockdown and changes to those measures would have been helpful from an employer perspective. Firstly, we would have known what we needed to do in advance to respond in the workplace and secondly we would have had more time to consider how to inform and reassure staff. Given our role in communities as a trusted NHS and emergency services

organisation, advance notice would have enabled WAST to be better prepared in order to best convey messages to the community and support the aims of them through our interactions with patients and others.

73. Throughout the pandemic, I do not think that the Welsh Government should have sought any additional advice from WAST. When we asked for specific support, the Welsh Government did what we wanted them to do.

74. I have been asked whether, in my view, the Welsh Government gave sufficient consideration in its decision making to the impact of NPIs on at risk and vulnerable groups in light of existing inequalities. I am unable to comment upon this as our contact with vulnerable groups is limited to when a response is required to an urgent care or emergency need and as such is not routine in nature.

F. Hospitals

75. I am asked to provide a chronology of what were, in my view, the core decisions made by the Welsh Government on hospitals as regards the discharging of patients, the use of DNAR orders, and the management of hospital capacity in which I was involved either by way of providing advice to the Welsh Government or attending meetings in which such decisions were taken by the Welsh Government.

76. Neither I nor other WAST representatives directly advised the Welsh Government in this regard. However, early on in the pandemic, I attended meetings with Dr Andrew Goodall and the other Chief Executives, the aim of which was to offer advice to the Minister and I was peripherally involved in this. We advised upon measures including that all elective care should stop temporarily so as to preserve hospital capacity and clinical capacity and capability across the care pathway. A letter was written from NHS Wales to the Government providing such advice. The Welsh Government followed the advice that was offered and elective surgery was stopped (See: **Exhibit JK/21 – INQ000275148).**

G. Test, Trace, Protect

77. I have been asked to provide my view as to whether the Welsh Government's core decisions in respect of testing, including capacity for testing, adequately prioritised health care workers. With the benefit of hindsight, I consider that the initial roll out of testing was inadequate and sub optimal. To an extent we at WAST felt the need to 'lobby' somewhat for our inclusion. The access to and coordination and flow of information was also initially clunky. However, I understand the reasons for this. The system was set up

at speed and in my view, it was, unfortunately, inevitable that there would be a slow start and some teething problems. Once the testing regime was in full flow and on a regular footing it was satisfactory and the Health Boards were responsive with improvements. WAST staff had access to polymerase chain reaction ("PCR") tests and lateral flow tests.

H. Engagement with UK Government and UK Counterparts

78. I did not have any engagement with the UK Government or its representatives during the period 21 January 2020 to 30 May 2022 that related specifically to the Welsh Government's response to the pandemic. The only engagement that I had with the UK Government during the relevant period was in relation to Mobile Testing Units. However, this was purely with regard to obtaining funding and not about its deployment.

79. The lack of direct engagement between myself and UK Government did not hinder me in the performance of my duties as CEO of WAST because the provision of healthcare was a devolved issue dealt with by Welsh Government.

80. WAST remained well connected to the wider United Kingdom ambulance sector response through the peer group meetings of the Association of Ambulance Chief Executives (AACE).

I. Divergence

81. I consider that divergence between the Welsh Government and the other three nations in response to the Covid-19 pandemic was necessary from the perspective of an operational response. Waves of the Covid-19 pandemic were unfolding at different times and different parts of the UK had higher prevalence of Covid-19. As such, the response had to be divergent in order to effectively respond operationally to the different picture on the ground in, say, Lincoln from Cardiff. However, notwithstanding this, divergence was unhelpful in regard to compliance. The greater the variation in messaging, the harder it became for people to comply. This was particularly the case for those with families on both sides of the Wales-England border. This is not only a comment on the difference between the four nations but also on the differences within the nations.

82. Regional differences in rules also caused difficulties. We started with a very simple message at a national level at the beginning of the pandemic: "Stay at home." This was very easy and straightforward for the public to understand and easy for them to comply because it is clear and unequivocal. But, when regional variations in NPIs or the levels of restrictions that were in place began to be introduced, it became less clear what was

required of the public and where. In my view this made it more difficult for the public to comply because there may have been less certainty or clarity of what was required of them in given geographical locations.

83. The regional variations also made it difficult for us as an employer to provide advice to our staff about what they should and should not be doing in given locations. Operationally they were subject to national level requirements from WAST, which applied across the board regardless of location. However, as WAST Staff are highly visible members of a uniformed healthcare service. As such, their behaviour in the community outside of an operational setting, or when they were off duty mattered. They may be considered role models, and the public may look to them for guidance and leadership in respect of complying with NPIs etc. It was therefore vital that we could provide our staff with accurate advice and guidance. The regional variations made this a more complex and difficult task.

84. In summary therefore, divergence was, to an extent, necessary. However, it did create difficulties. For example, from an employer's perspective it was difficult to quickly assimilate all of the relevant information and messaging and translate this to the operational context for our people.

J. Informal Communications

85. I am asked to provide full details of any WhatsApp or other messaging groups with Welsh Ministers, senior advisers, and senior civil servants, in which I was a participant and where messages were concerned with the Welsh Government's response to the pandemic.

    a. Throughout the specified period I would directly text message Dr Andrew Goodall. I attach these messages as **Exhibit JK/22.1 – JK/22.8 comprising: INQ000275153; INQ000275154; INQ000275155; INQ000275156; INQ000275149; INQ000275150; INQ000275151; and INQ000275152**.

    b. I was also in a Chief Executives WhatsApp group but a review of this did not reveal any messages concerned with the Welsh Government's response to the pandemic.

K. Public Health Communications

86. In my role as CEO of WAST I provided regular messaging and communication with my workforce and the public via radio, tv and social media as regards to the Covid-19

pandemic. Such messaging was provided locally and nationally. However, I was not involved in the designing of the messaging with a view to garnering better behavioural management, I was simply conveying the messaging that existed at the time.

87. I have been asked to consider key areas which I consider worked well and areas in which I consider that there were issues in relation to Welsh Government's public health communications.

88. On reflection, given that the public sector in Wales is the nation's major employer, I am not sure that we used public servants to the best effect as ambassadors for messaging. We didn't arm people with sufficient information to convey those messages back into their households and communities. This was possibly a missed opportunity because the hundreds of thousands of employees could have acted as ambassadors with that messaging.

L. Legislation

89. I did not have any involvement in specifically advising and briefing Welsh Government on the public health and coronavirus legislation and regulations.

M. Lessons Learned

90. With regard to lessons learned by the Welsh Government and demonstrated in their response to the pandemic, I consider that the Welsh Government response from Wave 1 (March 2020 to May 2020) to Wave 2 (September 2020 to April 2021) became less blunt and more nuanced. The Welsh Government's response became more tailored to the circumstances and took into account evidence regarding how Covid-19 was being transmitted and how it affected people in different ways. As such, there was evidence of learning and attempting to make the response smarter as time went on. For example, in wave one the approach was 'stay at home' 'don't go out': a very blunt, clear unequivocal message. It was a significant restriction of people's liberty. But then, as more data became available and we gained a greater understanding of how the virus was spreading, there were changes to the NPIs and more regional variations. As I have indicated above, this created its own problems, but it was a clear demonstration of learning and attempts to adjust government interventions in more nuanced and targeted ways.

91. During the pandemic, the Trust took part in a Rapid Ambulance Sanitisation Project through the Small Business Research Initiative, in partnership with Welsh Government,

and the Ministry of Defence. This project was delivered in Summer 2020, finally resulting in the procurement of equipment. The project has now been implemented fully. In my view this was an excellent piece of work and this is a view that appeared to be shared elsewhere as the project was recognised with the St David's Day Award.

92. As each wave of the pandemic concluded WAST undertook a debriefing process to identify aspects of our response that worked well and those that needed revision. This process enabled us to update and enhance our plans for future waves, on each occasion learning from the last. Examples of changes to our response plans are, but not limited to, revision to our local pandemic command structures; adjustment to the extent of non-frontline redeployment; refreshed infection prevention and control measures and changes to our capacity and response planning.

93. I am asked to provide a chronology of all occasions when I gave evidence before the Senedd relating to the Welsh Government's response to the pandemic. I did not give evidence in person to the Senedd at any time during the pandemic. However, in June 2020 WAST submitted written evidence on the Trust's Covid-19 response to the Senedd Health, Social Care and Sport Committee. I exhibit this evidence to this witness statement as **Exhibit JK/23 – INQ000275157**.

Statement of Truth

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

Signed: Personal Data

Name: Jason Christian Graham Killens KAM

Position: Chief Executive Officer, Welsh Ambulance Service NHS Trust

Dated: 8/12/23