Witness Name: Dr Heather Payne

Statement No.: 1

Exhibits: 20

Dated: 28/07/2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR HEATHER PAYNE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 2 March 2023 referenced **M2B-WG-HP-01**.

I, Dr Heather Payne, will say as follows: -

Preface

1. I would like to take this opportunity to express my sympathies to those who lost in any way during the Covid-19 pandemic. Those who died, and their family and friends who were unable to be present at good deaths, or grieve loved ones well, are and were, in my thoughts throughout. I was, and am, especially conscious of the losses endured by prospective parents, young children, school pupils and young people who missed out on key life transitions, social interaction, support from friends, and learning throughout this time.

Introduction

2. I give this statement on behalf of the Welsh Government to assist the work of the Covid-19 Inquiry.

3. My statement will address the matters relating to the role I played in core political and administrative decision-making, how and why key decisions were taken on the use of non-pharmaceutical interventions and lessons learned from my experience during the period of time between the following two dates, 21 January 2020, and 30 May 2022

("the specified period"). The specific focus in my statement is on my role as Senior Medical Officer for Women's and Children's Health ("SMOWCH"), which is a professional advisory role, providing technical medical and health advice to numerous policy leads, and my consequential involvement in decisions taken during this period in the management of the Covid-19 pandemic. Please note that my role encompasses both Women's and Child Health.

4. I have been asked to provide this statement to the Inquiry because of my role as SMOWCH. I am also Chair of the Wales Screening Committee which supports Welsh Government health screening policy implementation, and my statement includes reflections on both these roles, in relation to the issues set out by the Inquiry. The Terms of Reference for this group is exhibited at **M2BWGHP01/01-INQ000271873**.

5. It was in my role as SMOWCH that I was asked to advise Ministers and Welsh Government policy officials about the implications of Covid-19 and the measures implemented to deal with it in relation to my specific areas of focus (women's, including maternal, and child health). In my capacity as Chair of the Wales Screening Committee, I also commissioned risk analyses from Public Health Wales Screening Division about the implications of Covid-19 for screening services.

6. In addition to these two roles, I co-chaired the Black Asian Minority Ethnic Covid-19 Advisory Group, that was established by the First Minister, with Judge Ray Singh, CBE. Hon LLD, and I discuss this role within my statement. The Terms of Reference for this group is exhibited at **M2BWGHP01/02-INQ000066077.**

7. I also represented the Chief Medical Officer ("CMO") for Wales on the UK Moral and Ethical Advisory Group ("MEAG"), which was established via the Department of Health and Social Care (reporting via the CMO England). MEAG had been set up in the Autumn of 2019, and was fortunately already formed to be able to offer advice to the UK Government and Devolved Administrations. Summaries of the views given by MEAG were published on the UK Government website sometime after the meetings.

8. Through my participation in MEAG, it became clear to me that the diverging nature of Welsh legislation and the devolved functions of health, social care and education required a specifically Welsh approach. So, with the permission of the CMO Wales, I set up the Covid-19 Moral and Ethical Advisory Group for Wales ("CMEAG-W"). I exhibit the Ministerial Advice for the establishment of the CMEAG-W at

M2BWGHP01/03-INQ000097679. The first meeting of the CMEAG-W took place on 6 April 2020. I discuss my role in relation to CMEAG-W in further detail below.

9. The relevant materials relating to the scope of this statement are intended to illustrate key aspects of the way I carried out my role and the manner in which advice was provided to the Welsh Ministers.

My role, functions, and responsibilities as SMOWCH

10. I was appointed to the SMOWCH post on 1 June 2018 and remain in that post, although I have taken on significantly broader professional advisory responsibilities – including women's health, not just maternal, as well as screening leadership and an equality, diversity, and inclusion champion role, since I was first appointed.

11. Prior to being appointed as SMOWCH, I was employed by Cardiff University as a Senior Lecturer in Child Health and Consultant Paediatrician in Caerphilly (1 May 1996-31 May 2018) and while remaining in that post, I was seconded to Welsh Government to perform the SMOWCH role. I was appointed in this seconded capacity in June 2011 for a 5-year period, following an open competition process, and the role was extended until 31 May 2018. After that, I was appointed substantively (i.e., not in a seconded capacity) to the role of SMOWCH.

12. In addition to my Senior Lecturer post, I also held an Honorary Consultant Paediatrician appointment at Aneurin Bevan Health Board during the period 1 May 1996-31 May 2011, and was Associate Dean for Disability Support in the Wales Postgraduate Medical School between 2005-2011. I left these roles when I took on the seconded role of SMOWCH.

13. I am a Consultant Paediatrician by training. I qualified in 1980, with a Bachelor of Medicine and Bachelor of Surgery from St. Bartholomew's Hospital.

14. The role of the SMOWCH is as a member of Senior Civil Service staff of the Welsh Government designated by the Welsh Ministers as the 'Senior Medical Officer'.

15. In the SMOWCH role I have worked across a wide range of policy departments and provided professional advice on all aspects of maternal and child health including in relation to public health interventions; primary and secondary care services; screening; specialist services; service standards; configuration; service development

and management; and quality and safety including serious incident reporting and externally commissioned reports and reviews.

16. I have also contributed to the CMO annual reports since 2012, in addition to developing and writing policy documents for a wide range of health care delivery areas. These documents inform Ministerial decisions, with the aim of facilitating health and care decisions that are clinically based; improve health outcomes and reduce inequalities.

17. In my role as SMOWCH, I am experienced in preparing Ministerial briefings and advising on lines to take, so as to support policy colleagues across the portfolio areas that fall within my remit. My role includes contributing to the preparation of proactive and reactive communications strategies; horizon scanning for likely public interest and managing the response to this.

18. Reporting arrangements for my work are via the designated policy lead(s) in Welsh Government. The value of my role is to bring an understanding of the clinical and person-centred approach into the Civil service policy apparatus and promote policy development that has validity and value for professionals and service users alike, and promotes Welsh Government aims of improving health and reducing inequalities.

Advisor to Welsh Government, Welsh Ministers, and Welsh Government policy officials

19. Over the course of my period in the SMOWCH role, I have gained considerable experience in undertaking high level policy development in a devolved Government setting, as well as working to enable NHS quality and safety development, clinical leadership, and quality assurance work across NHS Wales, and in step with policy and professional counterparts in all UK countries singly or as 4 country approaches. Before Covid-19, this involved chairing meetings of a range of committees for screening, children's, and maternity services, liaising with professional networks in maternity, women's, and children's services, and taking part in commissioning or leading specific projects in quality improvement or service development and coordination.

20. In terms of my role during the specified period, I was a regular attendee of the Welsh Government's Technical Advisory Cell ("TAC") and as SMOWCH, I took up a regular position of challenge and advocacy to promote a life course and equitable approach to decision making in the pandemic. I was particularly concerned that TAC should

consider how decisions would impact on children and young people, and all individuals and communities with protected characteristics.

21. As SMOWCH, I was also an invited member of some of the UK Scientific Advisory Group for Emergencies ("SAGE"). For a variable but short period in early 2020, I attended SAGE subgroup meetings, to ensure a WG presence and to pass on matters of relevance that were discussed before others from within Welsh Government were identified to take part who had specific modelling skills. For example, the liaison role I had initially performed was taken on by Dr Brendan Collins, Head of Health Economics within Welsh Government. I was also involved in the SAGE mental health and psychology group, but again after an initial relatively short period of attendance, this was taken on by Professor Ann John from Swansea University. In terms of my role at these meetings, I commented from a Welsh perspective, noting areas of legislative difference, and asking about equality impact measures.

22. My substantive SAGE involvement was through a sub-group of SAGE, the Children's Task and Finish Working Group. In comparison to some of the other more permanent sub-groups, the Children's Task and Finish Working Group was established for a limited period of time only, and then stood down (in early 2021). I argued for it to continue as I felt it had an important ongoing contribution to make but ultimately this view was not accepted.

23. The group was convened and co-chaired by Mr Osama Rahman, Chief Scientific Adviser, Department for Education (England), and Professor Charlotte Watts. My view of the group was that it served primarily as an information exchange. It did have involvement from England, Wales and Scotland, and occasional involvement from Northern Ireland, so this was a positive aspect. Overall, I found it a helpful forum in sharing information. However, decision making was hampered by the overall lack of good quality empirical evidence for interventions relating to covid transmission, control and non-pharmaceutical interventions in children and young people. There was also the problem that the lockdown response was outside experience and published literature. In natural disasters worldwide, the first response for children is to bring them into communities and establish schooling and play for mutual support. Our lockdown response to Covid-19, for many good reasons, produced the opposite, but that left the question about how to mitigate the possible harms those decisions were causing children and young people.

24. The Children's Task and Finish Working group did attempt to address and answer some important questions. There were numerous issues around whether schools should be open or closed, when and how any re-opening should happen, and the implications for staff and parents as well as pupils. The group operated in a collaborative way, and we were able to draw on modelling information provided by the modelling subgroup (Scientific Pandemic Influenza Group on Modelling (SPI-M-O)) and behavioural information from the sub-group focussing on that aspect (the Scientific Pandemic Insights Group on Behaviour (SPI-B)).

25. As a group, we tried to determine whether any other data analysis was required but the data available for children generally was much more limited. For instance, testing in children was difficult and it wasn't felt that testing a large cohort of children would add much to what was already known about infection. The evidence we did have was often quite contradictory and empirical data quality was not sufficiently good to allow firm evidence-based advice on changing what was in place (i.e., lockdown and school closures). It was incontrovertible that when schools reopened, infection numbers went up. So even though we were trying to refine the layers of evidence, there was a very firm fundamental fact that the more anyone came in close contact with during a day, the more infections increased. Even though the majority of children would not be severely ill with Covid-19, more spread inevitably affected older and more vulnerable populations, and would result in more deaths in older and immunocompromised people as well as potentially overwhelming the NHS – and this was the first order consideration for decisions about whole population controls.

26. A persisting controversy was whether face coverings in schools were effective in reducing viral spread, and whether hygiene measures such as surface cleaning helped to reduce case numbers. There were broadly speaking two polarised points of view in terms of face coverings, and the evidence was (and has remained) equivocal in terms of whether face coverings reduced transmission. All groups I was part of, engaged in discussion about trying to balance the risk of transmission with children's rights, the needs of disabled children, and the restrictions face coverings would result in. There were also considerations for the health and wellbeing of teachers and nursery workers in direct contact with children. Again, the absence of good quality empirical evidence offering a clear, scientifically convincing consensus view about face coverings made it difficult to change decisions that were initially made on a risk

avoidance approach (which is a reasonable approach in a situation of high uncertainty and potentially high danger from infection).

27. Within the Welsh Government, I established and chaired the Children & Schools subgroup, which reported to the Technical Advisory Group ("TAG"). I exhibit the Terms of Reference for this group at **M2BWGHP01/04-INQ000271531**. This sub-group was intended to be the Welsh equivalent of the SAGE Children's Task and Finish Working Group. The remit of the Welsh subgroup was to provide detailed and strategic consideration to the scientific and technical evidence on Covid-19 as it related to children, childcare and schools' settings. A key part of this role involved reviewing and filtering considerable amounts of evidence (during this time an enormous amount of 'preprint' publications appeared, approximately around 1,000 medRxiv papers published per month, with no formal peer review. I had to review many hundreds of these papers in depth for validity and generalisability to children, as I was the only person available with the academic and clinical experience to do so at the time, until more formal research support in the Covid Evidence Centre was established in March 2021. Any formal advice from the Children and Schools subgroup was taken through TAC, and most contributions were part of wider consensus papers.

28. In terms of contributors to the group, I was able to recruit a range of independent experts who attended, but not all were able to offer full commitment. One reason for this limitation we experienced was that we were not able to offer research funding in the same way as a number of Universities in England, and there was no specific funding available for expert opinion to be provided by external experts. Some did contribute very loyally to the discussions that took place within the Welsh Children & Schools subgroup, but others were not able to give the same commitment without additional resourcing. In hindsight, a clearer and more transparent process for how experts would be recruited, remunerated, and recognised, reflecting the different context within which we were asking them to participate, would have been helpful.

29. Most of the interventions for children were childcare or education focussed, rather than being healthcare per se. However, we did publish advice answering questions around how to mitigate the impact of lockdown on children and we also successfully managed to obtain an extension to the bubble arrangements that applied for babies under 1. I exhibit the First Minister's written statement notifying this extension at **M2BWGHP01/05–INQ000023281.**

30. Other healthcare-focussed guidance we issued for children included a guide setting out 10 top tips for promoting communication in early years children and hygiene messaging. We also published public information videos about what to look for in terms of Covid-19 symptoms in children and issued reassurance around vaccination safety. An example of the work of the subgroup was published by TAC on the 7 July 2020 which is the advice from the Children and Education subgroup on return to school and is attached as exhibit **M2BWGHP01/06–INQ000066277.**

31. However, as noted above, any formal advice was taken through TAC, and most contributions were part of wider consensus papers. One direct review summarised the pros and cons of face coverings in children and the importance of mitigating any unintended /unwanted effects, such as stigmatisation, impaired communication, cross infection from poor mask technique, and mask fatigue. I exhibit the consensus paper at **M2BWGHP01/07–INQ000221053.** Across all areas, there was a need to give clear, simple communications and this meant that some of the more nuanced positions that could have potentially been articulated had to be simplified to meet this overall requirement.

32. In my role as Chair of the subgroup, and in contributions to TAG, I persistently advanced arguments for the wellbeing of children, however because the first order decision had been made early on that preventing deaths was the most important priority, and these were most likely to occur in older age groups, measures for the wellbeing of children were consequently in the realm of mitigation and minimising avoidable harms. This was often discussed at TAG meetings, where death rates were the main focus of discussions and modelling activity.

33. It became quite rapidly clear that there was a close correlation between deaths and advancing age and comorbidity (i.e., that the risk of death to children as a whole was relatively low). As a result of the decision to reduce deaths and maintain a functioning NHS, in my view the overall wellbeing of children and young people could not be prioritised in pandemic decision making. I consider this to be a fundamental issue for future planning in terms of generational equity and ensuring that the harms experienced by children and young people as a direct and indirect result of restrictions, should be avoided by careful planning and evidence gathering.

34. I feel I was successful in promoting discussion about the value of school closures and face coverings in children and young people, but the weight of evidence tended

to support the view that school opening was associated with more social mixing by adults, which led to more infections, and so this resulted in decisions being taken for prolonged school closures. The use of face coverings, once instituted, despite equivocal evidence of its effectiveness, persisted for a prolonged time because there was not sufficient weight of evidence to lead to a change of policy. An evidence-based position on the effectiveness of face coverings should be sought before a future pandemic.

35. I was aware at the time, and remain of the view, that the Children & Schools sub-group was not as strongly external as I tried to make it- some experts were invited and rarely attended for the reasons given above in para 23. The group was predominantly Welsh Government officials who were needing advice for a range of ministerial portfolios, specifically health and education, with different agendas and priorities. Relationships with teachers and teaching unions were an important driver of topics for discussion with Education policy leads, with concerns generated by papers published in medRxiv, which needed to be reviewed so that policy colleagues could have answers for pressured meetings with teachers' unions.

36. On reflection, if I was establishing the Children & Schools sub-group again, I would make it a more formally established external children's advisory group, more like the external experts Scotland appointed to establish a standing group that met monthly. I would note that throughout the pandemic period, decisions were being made daily, and our Welsh group met weekly for a long period between May and October 2020, so meeting intervals would need to be determined by need.

37. In my experience, the sub-groups established in both England and Wales did not have sufficiently independent identities of their own, focused on children and young people's wellbeing, and both were subject to the first order decision of reducing deaths, which limited the effectiveness of each sub-group for the reasons given above in para 32. It would have been important to have a clearer focus on minimising harm for children and young people and effective alternatives to in person schooling. For example, support for poorer children who did not have appropriate computer equipment was well intentioned, but the funding provided was reported to have not reached many of those children who needed it by Education colleagues monitoring policy implementation. Physical restrictions (such as closure of playgrounds and limitation of daily outdoor exercise) also led to long term physical, social and

psychological harm to children and in future we must plan to do more to address or mitigate this risk.

38. I am proud of a large number of collective impacts that the Children & Schools subgroup (Wales) achieved to promote the wellbeing of children and mitigate harms, especially the wider recognition that children were becoming harmed as 'innocent bystanders' and needed specific consideration in all policies, in line with the Children's Rights Measure Wales 2011, and specific publications such as the "top tips" guide to improve communication opportunities for infants and toddlers in the pandemic, and influencing the policy decision to extend social bubbles for under 1-year olds so they could have more family/social contact. I exhibit at **M2BWGHP01/08–INQ000271771** a copy of the minutes where discussions took place about the support bubble arrangements for babies under 1.

Screening decisions during Covid-19

39. As chair of Wales Screening Committee, I commissioned risk analyses from Public Health Wales Screening Division about the implications of the pandemic for screening services. These risk analyses identified the need to suspend some screening services for logistic, staffing and infection control purposes. I exhibit at **M2BWGHP01/09–INQ000271452** the screening programme proposals submitted by Public Health Wales.

40. The known risks of pausing or delaying cancer screening (breast and bowel especially) were identified and steps taken to mitigate and minimise, but there was no realistic alternative in terms of staffing and premises in the face of lockdowns.

41. The necessary delays were a ministerially taken decision and included plans to restart as soon as possible and harm minimisation by attempting to stay within the outside bands of acceptable round length.

42. Antenatal, Newborn, and Infant screening programmes continued throughout the pandemic. However, in order to enable infection control, restrictions were put in place in terms of partners being present at these appointments. This decision was taken by Health Board Infection Prevention Control leads and Directors of Nursing who are responsible for infection control. This was because consideration needed to be given to the total number of pregnant women each sonographer was seeing on a typical day and the increase in risk that would have occurred if each woman had been allowed to have a partner present. There was distress due to these restrictions,

especially at screening scans, for instance, where bad news or concern was imparted. Some discretion was permitted, on a clinical basis, with this implemented at a local level. Although consideration was given to trying to set out what some of these categories might be, there was very little evidence to base such an approach on and so it was agreed that the general approach would be not to allow partners to be present and leave this for local implementation.

43. On reflection we had to take a risk averse approach in pregnancy as we had no idea whether there would be long term adverse outcomes such as with Zika virus. Decisions were necessary in risk terms but difficult to administer due to the need to impose such restrictions at such an important personal and social event in family lives. Research in pregnancy is always slower to be produced and I would like to see the production of evidence in pregnancy prioritised. Workplace policies to protect women in pregnancy also need to be prioritised, as we did for NHS and social care workers. Teaching professions employed by Local Authorities did not always seem to offer the same level of precaution for pregnant mothers.

Race equity during covid

44. I co-chaired the BAME Covid-19 Advisory Group with Judge Ray Singh and provided leadership and coordination across this work throughout the pandemic.

45. I supported the production and implementation of the All-Wales Risk Assessment Toolkit (this work was led by a subgroup of the BAME Covid-19 Advisory Group, the Risk Assessment subgroup, chaired by Prof Keshav Singhal) and this was done within 2 months of the Risk Assessment sub-group being established, so that the NHS workforce was given effective risk assessment and support, to minimise avoidable workplace harm. The Terms of Reference for this subgroup are exhibited at **M2BWGHP01/10-INQ000271616.**

46. I attended multiple community groups reporting the lived experience of ethnic minority communities and ensured that the clear messages of exclusion and being under served were incorporated into the work of the overarching group, the workforce tool, and the socioeconomic report, which I drafted, structured and referenced and I exhibit at **M2BWGHP01/11-INQ000227599.**

47. The workforce risk assessment tool was made publicly available, and was used in NHS Wales, Social care services, also schools and Police forces and a number of

Local Authorities. An evaluation exercise reported that it was found to be valuable and useful in establishing confidence in the workforce, supporting equitable workplace conversations about risk management, and suggesting health promoting advice during the pandemic.

48. The First Minister's response to the BAME Covid-19 Advisory Group recommendations (exhibited at **M2BWGHP01/12-INQ000300238**) was published in September 2020 and accepted the report in its entirety, setting out the work that had already been set in train, and using it as the basis for the development of The Race Equality Action Plan: An Anti-racist Wales.

49. On reflection, the pandemic work led directly to The Race Equality Action Plan: An Anti-racist Wales, which is being implemented and which I am happy to retain an active part in, as a partner and ally addressing racism especially in the NHS and social care. This is exhibited at **M2BWGHP01/13-INQ000227788.**

Moral and ethical advice during Covid

50. I attended the Four Chief Medical Officers' Moral and Ethical Advisory Group ("MEAG"), convened in March 2020 and I exhibit the note of this first meeting at **M2BWGHP01/14-INQ000271872**. MEAG was established to provide independent advice to the UK government on moral, ethical and faith considerations on health and social care related issues, specifically in the context of Covid-19 but not restricted to this. It adopted the ethical framework for pandemic flu. However, although MEAG was convened on a 4-Nations basis, it rapidly became clear that it was really only able to serve England effectively, because of the different legislative framework in Wales.

51. Despite this practical limitation, I felt it was a valuable and erudite group, and so I gained permission from CMO Wales to set up a specifically Welsh group to consider and advise on legal, moral, and ethical issues.

52. The Covid-19 Moral and Ethical Guidance for Wales Advisory Group ("CMEAG-W") was established in April 2020. At the same time as CMEAG-W was established, Welsh Government published a statement that CMEAG-W advised on, which set out values and principles for NHS Wales to use in guiding decision making for health care delivery during the Covid-19 pandemic in Wales, a copy of the statement is attached as exhibit **M2BWGHP01/15-INQ000271482**. This was followed rapidly by

the publication of our Terms of Reference (May 2020) which are attached as exhibit M2**BWGHP01/16- INQ000066079**.

53. CMEAG-W was established as an inclusive group, and represented a broad cross section of the community, including older people and children's commissioners, disability and learning disorder voices, faith and belief groups, Welsh language commissioner, clinicians, trade union, legal, human rights, NHS management and ethical experts. From the outset, it was a cohesive and greatly valued group, jointly sponsored by the Minister for Health, the Deputy Minister, and Chief Whip and the Minister for Housing and Local Government. It reported to the CMO and sponsoring ministers. From its establishment I acted as Chair.

54. In terms of how CMEAG-W could be approached to advise, we developed a pro-form referral form that needed to be completed, setting out the issue/question on which advice was sought.

55. Policy leads were encouraged to bring policy proposals to the group for analysis and advice and finalise their policies in light of the feedback. It was found to be a constructive and helpful forum, and resulted in some significant changes of direction, including on covid certificates, vaccine prioritisation and access, reducing risk of moral distress in staff, amongst others. I exhibit at **M2BWGHP01/17-INQ000271769** a discussion paper brought to the October 2021 meeting of CMEAG-W on 'Medical Exemptions for the Covid Pass in Wales' and the supporting minutes of that meeting at **M2BWGHP01/18-INQ000271798** which outlines the contributions made by the group on this particular issue.

56. On reflection, it would have been helpful to publish our analysis and advice more widely. Although summaries from meetings were published on the Welsh Government website, these were not always timely due to lack of translation resource. However, the values and principles statement were widely used and has been found very useful in a wide range of contexts where there is dilemma about resource allocation, service development or new technologies. There have been requests from a number of colleagues to provide further advice and suggestions that it would be helpful to continue the group, as a legacy body, to enable an ongoing advisory role. The outputs from CMEAG-W were published descriptively in 2022 as part of a Nuffield ethics project report. I exhibit this report at **M2BWGHP01/19-INQ000271874.**

57. I prepared a summary of CMEAG-Wales in February 2022 and which I attach as exhibit **M2BWGHP01/20-INQ000271754.**

58. Building on the success of CMEAG-W, I hope to promote more consistent and available clinical ethics activity through NHS Wales via a clinical network of multidisciplinary groups to offer the broad perspective and voice that CMEAG-Wales was able to offer.

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

Dr Heather Payne
Senior Medical Officer for Women's and Children's Health
Welsh Government

Dated: 27th September 2023