Monday, 30 September 2024

(10.30 am)

(Proceedings delayed)

(10.34 am)

MS NIELD: Good morning, my Lady. May I please call Professor Sir Frank Atherton, who can be sworn.

PROFESSOR SIR FRANK ATHERTON (sworn)

Questions from COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: Welcome back, Sir Frank.

A. Thank you, my Lady.

MS NIELD: Can you give your full name, please.

A. Yes, I'm Dr Frank Atherton. Francis officially, but Frank, everybody knows me as Frank.

Q. Now, I think despite the fact being formally Professor Sir Frank Atherton, you've indicated that you would prefer to be called Dr Atherton; is that right?

A. That's how the people of Wales would know me so I prefer that, thank you.

Q. Thank you.

You have provided two witness statements to this module of the Inquiry. That's INQ000416178 dated 21 February 2024 and INQ000474224 dated 1 May 2024. You are familiar with those statements and I think you have a copy of each of those in front of you; is that right?

A. I am and I do. Thank you.

Q. If we could deal, first of all, with your professional background and your career, please, Dr Atherton, you studied medicine at Leeds University going on to work in a broad range of medical areas before you completed your training in general practice, and later going on to undertake specialist training and then to practise in public health, I think initially overseas and then in the UK; is that right?

A. That's correct, yes.

Q. And I think you were the Deputy Chief Medical Officer for Nova Scotia in Canada before taking up your current role as the Chief Medical Officer of Wales in August 2016; is that correct?

A. That's true.

Q. I think there has in fact been a Chief Medical Officer for Wales since 1969; so predating devolution; is that correct?

A. As far as I understand, yes.

Q. And the Chief Medical Officer is a director-level post within the Welsh Government, and you report to the Director General of the Health and Social Services Group; is that correct?

A. I do, yes.

Q. I think at the start of the pandemic, the Director General was Sir Andrew Goodall and then later in

November of 2021 he was succeeded in that role by Judith Paget; is that right?

A. That's correct, yes.

Q. You have explained in your witness statement that while the Chief Medical Officer role is a member of staff of the Welsh Government, your role requires you to retain a high degree of independence and separation from the concerns of government, and you are providing your advice without regard to government policy or direction; is that correct?

A. That is correct, yes. I have a degree of independence so I can bring issues that the attention of ministers if I feel it's appropriate to do so, yes.

Q. I think your advisory role to the Welsh Government during the pandemic was twofold. Firstly, you attended cabinet and advised the First Minister and cabinet in relation to lockdown measures and other interventions aimed at controlling the pandemic for the population of Wales generally; is that right?

A. Mm-hm.

Q. And secondly, in relation to matters within the scope of this module, you provided advice to the Minister for Health and Social Services; is that correct?

A. That is correct, yes.

Q. And I think you've clarified that decisions on the

healthcare system response to Covid-19 were not taken at cabinet; they were a matter for the minister; is that correct?

A. They would largely be led by the Minister for Health and Social Service, or social care, through Andrew Goodall as the chief executive of the NHS, yes.

LADY HALLETT: Could you keep your voice up.

A. I will try, my Lady.

LADY HALLETT: Thank you.

MS NIELD: Can we look, please, at paragraph 79. That's page 27 of your first witness statement.

Thank you.

You explain there that there was a weekly -- from mid-April to October 2020, a weekly check-in meeting with the First Minister and the Minister for Health and Social Services, attended by key officials as well as yourself and Dr Robert Orford. I think Dr Robert Orford was the Chief Scientific Adviser for Health for Wales; is that right?

A. That's correct, yes, he was.

Q. "This was a 'sitrep' style meeting and the updates from myself and Dr ... Orford would inform the First Minister and enable him, along with the Minster for Health and Social Services to set the tone for the priority areas for officials that week ... This would include

discussion on the wider healthcare response, but at a high level (as oppose[d] to operational detail) with a focus on the assessment [of] NHS capacity."

Two questions arising from that, please, Dr Atherton: who provided the information on NHS capacity to the minister?

A. So I think by this stage the planning and response cell had already been created within the health and social care group, and they were monitoring what was happening in the NHS, reporting that through to Andrew Goodall and myself, and there would have been -- there was updates to the minister and the First Minister on those aspects as well as on the public health aspects of the pandemic.

One thing I should add, and I can't remember whether it was in every occasion but Andrew Goodall, as the chief executive of the NHS, would often have been at those meetings as well.

Q. Thank you.

In terms of the operational detail about what was happening in the healthcare system in Wales, if that was not provided during these weekly check-in meetings how was the minister kept informed about operational issues in the NHS in Wales during the pandemic?

A. As I say, on occasions certainly Andrew would have been at those meetings, and I'm sure the minister and the

First Minister were having separate briefings from Andrew and other policy leads leading on the planning and response work. So this wasn't the only occasion that a minister and First Minister would have had opportunity to talk to policy officials, such as myself, but there were a range of opportunities for them to fully appraise themselves of what was going on.

Q. And were you providing any detail about operational issues that were arising in the NHS to the Minister for Health and Social Services?

A. I would have been having broad overview of where the system was, whether we were running towards capacity, problems. I wouldn't have had the operational detail, as you describe it.

Q. Thank you.

I understand that as the Chief Medical Officer for Wales that is a dual role: you're also medical director of NHS Wales; is that correct?

A. That is correct, yes.

Q. Is that an advisory role or a decision-making role?

A. It's an oversight role. It's to provide leadership across the health profession, particularly the medical profession of course, within Wales, to act as the senior responsible officer. So all doctors have to follow re-validation procedures and that escalates up to the

medical director, and to liaise with the medical directors in health boards, who were responsible, of course, for the operational delivery of health services within each of their own individual health boards.

Q. We will see in due course some documents that are badged "NHS Wales". I think it's right that there isn't a single entity called "NHS Wales" but there are a number of NHS bodies that make up the NHS in Wales, and that includes seven local health boards who are responsible for providing primary and secondary care within their geographical area; is that correct?

A. Yes. You describe the architecture very well. Seven local health boards, a number of health trusts, no such thing, as you rightly say, as NHS Wales, although in more recent times an NHS Executive has been created. So perhaps there is a move post-pandemic towards a more recognisable NHS Wales. But that at the time was the correct position.

Q. And I think each of those local health boards in Wales has its own medical director. In your role as medical director of NHS Wales, did you have any power or authority to direct the medical directors of the local health boards?

A. No.

Q. And how would you characterise then the relationship

between the medical director of NHS Wales and your role in that capacity and the medical directors of each of the local health boards?

A. So I was a member of the medical directors' group, I used to chair the medical director meetings which would happen once every month and we'd use those meetings to discuss matters of policy, which were emanating from Welsh Government, so that medical directors in local health boards were kept aware of them and they would use the opportunity to discuss issues around Health Service delivery with me. But it wasn't a power relationship in the way you describe it. It was more of a first among equals, let's say.

Q. Did those monthly meetings continue throughout the pandemic?

A. They did.

Q. And when you were meeting with the medical directors of the local health boards during the pandemic, was that a two-way flow of information? Were the medical directors communicating to you the issues that they were encountering within their hospitals or within primary care in their areas?

A. Yes, of course we moved, as everything did, towards virtual meetings as opposed to physical in-person meetings. The meetings continued and there would have

been a two-way flow of information exactly as you described. Thank you.

Q. And in terms of any issues or particular concerns that were brought to your attention during those meetings with the medical directors of the local health boards, was there any mechanism by which you could share that information with relevant Welsh Government officials and, indeed, the Minister for Health and Social Services?

A. So I would attend those meetings along with Chris Jones, my deputy, Deputy CMO. Chris and I would feed -- any issues which were escalated to us we'd feed in two different directions. If there's anything that required the attention of ministers or the First Minister, then I would obviously bring them up to speed with issues. But the main route to solve problems would have been more through into the planning and response group which was leading the policy work around how the NHS and social care system responded.

Q. You've mentioned your deputy -- I think that was Dr Chris Jones --

A. Yes.

Q. -- during the pandemic also attended those meetings. I think in his witness statement -- I don't think we need to get it up -- he's also described himself as

a medical director of NHS Wales.

Was that -- were you both medical directors effectively on an equal footing or was he your deputy medical director?

A. I think what Chris is referring to, and if we read it we could bring it up, but he was at one point -- before I arrived in Wales, he was formerly the medical director. I think when my predecessor, Dr Ruth Hussey, arrived I think she became the medical director and Chris became the Deputy Chief Medical Officer and that was the arrangement I inherited when I arrived in 2016.

Q. I think Dr Jones explained that prior to the pandemic you fulfilled the main leadership role as Chief Medical Officer for public health and he provided support mainly for the role of medical director. Did that division of roles between you remain the case or did that change during the pandemic?

A. I think it was broadly -- it broadly remained the same. Chris Jones is of a highly skilled cardiology background and had a deep understanding -- had worked in Wales for many, many years, a deep understanding of the healthcare system, and so there was a natural division of responsibilities that he led on a lot of the healthcare work, not exclusively, there was always overlap, but I come from a public health profession, public health

background, as you described earlier, and so it was natural for me to lead on more of the public health issues.

Q. I think you were also -- as well as Chief Medical Officer, medical director of NHS Wales, you were also the director of the public health directorate at least for the first two years I think of the pandemic. Is that right?

A. There was a directorate which was within Welsh Government when -- and I was the director of that directorate, excuse me. It had various names over time and I think by the time the pandemic arrived it was the population health directorate.

Q. So that was in relation to your public health responsibilities?

A. It encompassed the public health work but also some of the medical director roles which Chris, as you rightly say, as deputy, was leading on. So, for example, there were a number of major health conditions which the directorate was responsible for as well.

Q. Thank you.

In terms of the Chief Medical Officer's Covid-19 response team, can we look, please, at an organogram of that system -- thank you.

This is INQ000066199, and can we have a look

please at page 3. Thank you.

You are named there, Dr Atherton, as having responsibility for governance and resources and also oversight.

And if we can go over to the next page, page 4 please.

This is the structure and functions of the Chief Medical Officer's Covid-19 response team, and in blue along the top line we can see the principal bodies with whom I think the Office of the Chief Medical Officer liaised and then the different subgroups or cells that make up the response team are in pink boxes around the centre.

I make it 21 cells in that team. Would it be right to say that there was a lot of work being done by the Office of the Chief Medical Officer on many different areas?

A. It would.

Q. And I think up until April 2021 when Dr Gillian Richardson was appointed as an additional Deputy Chief Medical Officer to lead on vaccination issues, you were assisted by just one deputy. That was Dr Chris Jones; is that right?

A. That's correct, yes.

Q. What's the situation now? Are you assisted by two

deputies currently or just one?
A. Relatively recently we appointed a second Deputy Chief Medical Officer, DCMO, and so there's a division of labour again, with -- Chris Jones, you understand, has retired from Welsh Government now and so there's a direct replacement for him but we also have an additional Deputy Chief Medical Officer working on the public health side, a former public health director who understands the public health architecture and system.
Q. Dr Atherton, you explained in the Module 2B hearings that there was a lack of administrative support within the Office of the Chief Medical Officer prior to May 2020 which meant that you had no minutes taken of your meetings prior to that date with the UK Chief Medical Officers or your meetings with Public Health Wales.

Do you consider that in the event of a pandemic there needs to be more than one Deputy Chief Medical Officer to support the Chief Medical Officer and additional administrative support?
A. Well, in terms of the number of deputies that's a moot point I think. I do think we were under-resourced, certainly compared with other UK nations, in terms of senior leadership, and that certainly was an issue. We tried to address that by bringing in health

professionals. Gill Richardson you have mentioned, there were a number of other retired health professionals that we brought in.

The administrative issue was extremely difficult because, as perhaps the diagram demonstrates, there was a huge amount going on at the time. There was a river of information which was flowing extremely fast. It was very difficult to maintain an understanding of that and, at the same time, keep the administration of the office in place.

I remember having quite early in the pandemic quite a lengthy discussion with my counterpart in Scotland, Dr Catherine Calderwood, about the way that my office was structured and she was horrified, I would say, that we had the resource that we had to be able to deal with the issues we were facing.

So, yes, we did feel under-resourced. It was difficult and it was an extremely busy time. The individuals, some of whose names appear there and many of whom are redacted, did a fantastic job. We pulled people from all across the public health directorate -- the population health directorate to take on new functions and they did that willingly and with great aplomb.

In my mind there should have been a broader Welsh

Government reallocation of responsibilities, and I think I covered that in Module 2B, as you say.
Q. Can we turn, please, to the Welsh Government oversight of the NHS in Wales during the pandemic period.

I think it's right, as you have said, that there's no single organisation which is the NHS, NHS Wales. I don't think there was a single organisation that could take national command and control of the NHS in Wales during the pandemic; is that right?
A. That's correct, yes.
Q. In February of 2020, the Health and Social Services Group Covid-19 Planning and Response Group was established within the Welsh Government Health and Social Services Group; I think that's right?
A. Can you give me the date again?
Q. February of 2020.
A. That sounds about right, yes.
Q. And can we get up, please, page 2 of this document which is on screen.

And that sets out, I think, the structure of the Covid-19 Planning and Response Group. That's situated in the middle of that diagram, and it reports to a group of five people, including yourself as Chief Medical Officer. Albert Heaney I think was the Deputy Director General responsible for Social Services; is that

correct?
A. He was the director of social care and also acted, yes, as Deputy Director General, correct, yes.
Q. Jean White, the Chief Nursing Officer, and Samia Saeed-Edmonds of the Covid-19 Planning and Response Group. And there are a large number of cells and subgroups we can see below the planning and response group in the middle there that feed into the Health and Social Services planning and response group.

Did you chair or have membership of any of those cells that we see along the bottom? I think your deputy was a co-chair of the Acute [and] Secondary Care Cell.
A. No, I did not.
Q. In his role as co-chair of the Acute [and] Secondary Care Cell, did Chris Jones report to you or keep you updated? Were you sighted on his work?
A. Yes, absolutely.
Q. If we can look at some of those subgroups that feed into the planning and response group, there's the Technical Advisory Cell on the right of this document, which I think we'll come to in due course, and that was co-chaired by the Chief Scientific Adviser for Health?
A. Yes.
Q. There's the PPE Supply Cell that feeds into the Planning and Response Group. There's the Essential Services

Cell. Was that group concerned with essential health services, effectively priority non-Covid healthcare?
A. That's my recollection, yes. The essential services which was important to maintain and to keep running throughout the pandemic, yes.
Q. And then in terms of the Acute Secondary Care Cell, I think you have explained in your witness statement that that subgroup was in charge of discussing and planning the hospital response to the pandemic and that included areas such as critical care, ventilators, the Covid treatment pathway, maintenance of non-Covid care, field hospitals, end-of-life care; is that right?
A. Yes, that's my recollection, yes.
Q. And I think Dr Jones sets out in his witness statement that in addition to his role on this Acute Secondary Care Subgroup, he regularly attended meetings with Andrew Goodall and the chief executives of the NHS organisations in Wales. Were you present during those meetings or did he report those back to you?
A. Very often we would both be present. I would give an update to chief executives of the epidemiology where we were up to. Chris would talk about the NHS response and where perhaps there were issues that chief executives needed to be aware of, yes.
Q. I think Dr Jones also had some early involvement in

issues around PPE supplies for the healthcare sector; is that correct?
A. He did. Chris stepped into that role very early on when there was an anxiety about the levels of PPE stocks that we were holding. Subsequently, the supply cell, chaired there by Alan Brace, who was the director of finance actually for NHS -- for the Health and Social Care Group took over the leadership of that role.
Q. And I think Dr Chris Jones -- I think you and the Chief Nursing Officer established the Nosocomial Transmission Group in April or May of 2020 which was co-chaired by your deputy with the Chief Nursing Officer; is that correct?
A. Exactly.
Q. We'll come on to the work of the Nosocomial Transmission Group a little later.

I think in your witness statement you have said that neither you nor the Office of the Chief Medical Officer for Wales were involved in advice on the identification or characterisation of the post-Covid conditions such as Long Covid, and you weren't involved in formulating protocols or guidance around that condition. I think it's right that your deputy, Dr Chris Jones, was a member of the Welsh Long Covid subgroup that was established in November 2020; is that

correct? Do you recall that?
A. I don't remember but it wouldn't surprise me.
Q. I think he's named in the draft terms of reference for that group. Would that accord with your --
A. It would have been appropriate, yes. I don't think he chaired that group, though, but he may well have been a member, yes.
Q. Did he report back to you as he was your deputy regarding the work he undertook as a member of that group?
A. I don't recall any specific briefings on that but -- no, I don't recall any.
Q. All right, thank you.

Reflecting then on the response of the Welsh Government's Covid-19 planning and response structure and looking at that organogram, do you think that that was an effective structure for dealing with the many issues that arose in the healthcare system during the pandemic? Do you think it would have been better to have a separate national overarching body to co-ordinate and lead the NHS?
A. Well, I mean, the organogram that we see there is a point in time. I suppose it evolved over time as well. I'm not quite sure the date that this refers to but I do recognise it. Did it work well? Well, it certainly

worked. The flow of information seemed to work and it's notable, isn't it, that, you know, it follows up towards the Minister for Health and Social Services so that he was kept informed as to what was going on.

I think the issue you touch on is an important one. It's about the command and control of the NHS, is it not? Is that what you're asking about?
Q. Yes, that's essentially the question.
A. There is a history to this. When I arrived in 2016 in Wales, there had been a report by the OECD, the Organisation for Economic Co-operation and Development, which had looked at -- actually, there had been a report on each of the four nations and it looked at the strengths of the Welsh health system, small in size, seven local health boards, reasonable size, but it did make the comment that there was insufficient ability to have a command and control arrangement within Wales.

That's something which has bubbled around, I would say, ever since I've been there and it certainly was a feature when Covid hit us. Subsequently, as I say, there has been the creation of a national NHS Executive which is designed, was designed, to have that stronger guiding hand, let's say. I think that was the term used in the OECD report.

So in Wales things are done by collaboration and

when you have a pandemic like this, there is a need to move to a more directive approach, I believe. I think to some degree that did happen. Andrew Goodall as the Chief Executive of the NHS, alongside being the Director General for the health and social care group -- he has two roles in that regard -- I think did a good job in terms of corralling the local health boards, making sure that they knew what was expected of them. But it was done on the basis of collaboration rather than direction, I think, and I think that is a weakness, has been a weakness, in the health system which the NHS Executive system is designed to try to put right.

Q. This NHS Executive, does it have any statutory basis?

A. I can't tell you the -- it is -- I'm sorry, I don't know the legal entity of it.

Q. But what I'm getting at, Dr Atherton, is, does it have the legal power or authority to be able to lead NHS Wales? Does it have authority to take national command and control or would that remain with the local health boards?

A. I think it's a work in progress. It is a fact in Wales that the local health boards are sovereign organisations that have to manage their own system within their own budgets. I don't think -- I could be wrong but I don't

think the NHS Executive currently has the ability to direct in the way perhaps which is envisaged when the OECD report was produced in 2015.

Q. I think it's right, isn't it, that the local health boards, the seven local health boards are each designated as category 1 responders under the Civil Contingencies Act?

A. Correct.

Q. If we can move on, please, to look at co-operation between your office and the other UK nations, you've explained that as the Chief Medical Officer you played a key role in sharing information and practice between Wales, the healthcare system in Wales, and that of the other nations and feeding back to the Welsh Government, and that took place predominantly through the meetings with the four UK Chief Medical Officers; is that correct?

A. That's correct, yes.

Q. How would you describe your working relationships with your counterparts in the other nations?

A. They were excellent. I don't think we could have asked for closer collaboration really. Professor Whitty, Sir Chris, had taken up the post of Chief Medical Officer for England and the UK aspects of the role not long before the pandemic struck, of course, but we'd

already developed a relationship. He had spent a lot of time in building the relationship and the trust between the four of us. We settled into a pattern of meeting regularly on a quarterly basis in person and regularly as needed and so the relationship was excellent.

I think actually having that pre-existing relationship before the pandemic struck really helped us to remain as a coherent group that worked very closely together.

Q. In addition to the regular Chief Medical Officer meetings between the four UK Chief Medical Officers, I think you also all met weekly at a Senior Clinicians Group, which included a wider membership. What were the issues discussed at those senior clinicians groups and how did you feed back relevant information for the Welsh healthcare system from those meetings?

A. So the Senior Clinicians Group originally was set up as an England-only body but Chris, Sir Chris Whitty, rapidly realised that there was a benefit in extending that to the other devolved nations and so myself and colleagues were invited. Our Chief Nursing Officer colleagues also joined the group.

Q. What issues were discussed there?

A. So it would be matters relating to any clinical issues which were of relevance, some of the research and

development findings, in early days in the findings, would be brought to that group, issues around testing strategies would be discussed, the IPC cell would have brought issues to the group for notification so that we knew what was going on in the cell there. It was also a forum for sharing information, as the Chief Medical Officer meetings were as well. It was a slightly wider group.

So a very broad range of clinical issues, really, I would say, yes.

Q. How did you feed back to the officials and the minister in the Welsh Government?

A. So my habit in these meetings was to try to keep my own notes. We talked about the lack of administrative assistance. So I tried to keep my own notes of really quite complex issues which were being discussed and complex papers which were being presented. So I would maintain my own notes and where there was something that was directly relevant either to the ministers or to other people in Welsh Government, or the policy leads, I would try after the meeting to drop an email or to include that in my briefings to the minister and the First Minister.

Q. As you had this dual role which we've spoken about, the medical director of NHS Wales, did you or indeed your

deputy ever meet with the National Medical Director of NHS England or medical directors of the other devolved administrations as part of the Senior Clinicians Group or through any other means?

A. Well, the medical director of England was a member of the clinical group we just described so we met with him regularly. There were issues occasionally, not frequently, where we had specific problems in Wales where I needed to contact the national -- the UK medical director, Sir Stephen Powis, but that would have been quite infrequent really, if we needed, for example, mutual aid on specific issues across the board and between England and Wales.

Q. And arising from these Senior Clinicians Group meetings and in relation to the oversight of healthcare services and the healthcare sector's pandemic response, were you aware of the Welsh Government response ever diverging in a significant fashion from the approach in England?

A. On healthcare responses?

Q. Yes, in terms of the way that the pandemic response of the healthcare systems. Were you ever aware of a divergent approach from what you were hearing from your counterparts in the devolved administrations?

A. I can't recall any specific instances. I mean, there may well have been later in the pandemic, I'm sure we're

going to go and talk about oximeters, we had a different use to the approach of use of oximeters.

Testing was a bit of an issue, the testing strategies generally, I mean. Although information on the public health basis flowed very smoothly, I think, between the Chief Medical Officers, sometimes -- because the work -- understandably, because the work was being undertaken so rapidly, sometimes policy leads at UK level, in England, let's say, didn't communicate as rapidly as I would have liked with colleagues who were working on similar issues in Wales and that did lead, I think, to some divergence and some difficulties in keeping up with everybody was doing.

Q. What do you think would be a solution to that communication issue, if I can put it in that way?

A. I think in the same way that Chief Medical Officers met and continued to meet regularly, there needs to be more communication between policy officials, policy leads, between the four nations. I think to some degree that is already happening but that to me would make far more sense.

It's very difficult in the heat of a pandemic, of course, because work was being often directed by, say, the Secretary of State at UK level and it was very difficult, I think, for policy officials there to always

remember to link up as closely as they might with policy leads in the other devolved nations. It's something we need to continually work at as civil servants, I think, as the Civil Service generally.

Q. Thank you.

Can we move on, please, to look at sources of scientific knowledge that was made available to you as Chief Medical Officer and the developing understanding of Covid-19.

Your second witness statement to this module sets out those matters and you explain that in making that statement you had access to contemporaneous documentation to assist you to recall your state of knowledge at the beginning of the pandemic in March 2020, and that documentation includes updates that you received from the Technical Advisory Cell, the SAGE briefing papers, and emails from Dr Orford in which he summarised what was discussed at SAGE meetings. Is that right? That was the documentation that you had access to?

A. Yes, that was broadly the flow of information, yes.

Q. Did you keep any notes or records yourself of the information that you were receiving about Covid-19 and any significant developments in the scientific understanding of the virus?

A. I didn't keep any formal notes as such. I think as the Inquiry knows, I keep a day book where I scribble outcomes of meetings I have and just as aide-memoires to myself, so there may be issues in there. Those have been disclosed, of course, to the Inquiry but no formal notes of that information, no.

Q. Can we look, please, at page 2, paragraph 4 of that witness statement. You say that you have now had the chance to consider these contemporaneous documents we have just referred to:

"... with the benefit of time, during the pandemic I was often being sent considerable amounts of information to consider and assimilate daily. Therefore, the summary information rather than the detailed information contained in papers was often my primary source of information."

Is that right?

A. That's absolutely right, yes.

Q. So is it the case that where you have referred back to SAGE papers or Technical Advisory Cell briefings to identify what you understood about Covid in the early part of the pandemic, it may be that you hadn't in fact read those detailed papers at the time; you were relying on a summary?

A. That would be correct. I mean, at the time, just to

expand on that slightly, you rightly mention -- so a TAC summary, a Technical Advisory Cell summary, would come to me and that would be a very lengthy summary, sometimes 30/40 pages, and embedded in that would be all of the SAGE papers, for example. So it would have been impossible -- this is what I referred to as the river of information flowing very fast, it was in spates, and it would have been impossible for me to understand the detail of each of the individual papers, and in a way that's why we set up the system where Rob Orford, as the chief science officer for health was attending SAGE, collecting that information, bringing it back, working with the TAC, the Technical Advisory Cell, to summarise it, and bring that to me in a way that I could then absorb and summarise for the health minister and the First Minister, yes.

Q. So if we can take that in stages in a chronological order, please, I think it's right that prior to 11 February, when Dr Orford first attended SAGE, information from SAGE and indeed from NERVTAG was conveyed to you through your meetings with the four nations' Chief Medical Officers; is that correct?

A. That's correct. I think that's correct, yes.

Q. And the Welsh Government I think wasn't invited to SAGE until that date in February, 11 February; is that

correct?

A. I believe so --

Q. That's from your witness statement.

Prior to setting up the Technical Advisory Cell, if Dr Orford was giving you these updates verbally, were you recording those in any way, these verbal updates?

A. Only in the way that I previously described as to meetings and discussions I had. I would make notes in my day book. There may be records there but no formal note of meetings. These were not minuted meetings, you understand. Things were moving extraordinarily fast.

Q. In terms of the witness statement that you provided to us, you haven't listed there as your contemporaneous documentation to which you've referred any of your day books or notes. Did you go back and look at your day book or your notes of the time to see what your state of understanding was in March of 2020?

A. Can you ask that again in a slightly -- way that I can understand the question.

Q. You've explained -- perhaps we can have a look at paragraph 4 of your second witness statement -- forgive me, paragraph 5 of your second witness statement.

That's INQ000474224.

You explained earlier that you referred to contemporaneous documentation including updates from the

correct?

A. I think there had been a couple of meetings, preliminary meetings, of SAGE which the devolved nations were not invited to, and that then -- that invitation I think initially as observers and then subsequently as full members then became the norm. I can't tell you exactly when but at that point we identified Rob Orford as the right person for Wales, to be representing us.

Q. I think you were technically a member of SAGE; is that correct?

A. I was, correct, yes.

Q. Did you ever attend any meetings?

A. I didn't. No, I delegated at a very early stage. I recognised that I wouldn't be able to absorb all the information and do everything else that I was doing, so we very early on identified Rob Orford as the right person to represent Welsh Government.

Q. How did Dr Orford then keep you updated on the evolving information?

A. Exactly as I say. Well, he would talk to me, of course, so if there was any matters of the pressing issue, you know, he'd often verbally communicate to me. But then, as TAC became established, he would provide those written summaries through the TAC briefings.

Q. I think TAC was established on 27 February 2020; is that

Technical Advisory Cell, SAGE briefing papers and emails from Dr Orford.

A. Yes.

Q. I'm asking whether the notes that you've told us that you kept on an informal basis in your day books, whether you referred to those notes in finding --

A. I understand the question now, thank you.

Q. -- in producing this witness statement?

A. Thank you for clarifying.

Your question is did I -- have I systematically gone back through those notebooks. I have not. Those notebooks, as I'm sure you'll be aware if you've seen any of them, are scribbles. I can read some of them; I can't read all of them. I don't think it would be terribly helpful for me to go back to them. My main source of information would have been the TAC summaries and information contained in those.

Q. Thank you. We can move on.

We can take that down now thank you.

The Technical Advisory Cell, what was the membership of that? Was that a rolling membership? Were people invited to come to the advisory cell or was there a fixed membership of experts?

A. There were two constructs: there was a Technical Advisory Cell and a Technical Advisory Group. The cell

was a relatively small number of people in Welsh Government. I can't tell you just now exactly who were members but Rob Orford was the chair, Fliss Bennee -- Fliss, his deputy, was co-chair, and there would have been a group of civil servants within the cell who were compiling the information and summarising it.

There was a broader Technical Advisory Group which was much wider, drawn much more widely, which included people from a number of organisations, including academia and external organisations but also other departments within Welsh Government. So the cell and the group were related but slightly different constructs.

Q. So the cell was providing advice to assist you and to assist the Welsh Government?

A. The ministers, yes.

Q. What was the purpose of the Technical Advisory Group?

A. To get a broader perspective. And specifically it had a role in modelling. As the modelling which was being undertaken -- modelling of the pandemic, the epidemiological monitoring of the pandemic was being undertaken at UK level, we recognised that there wasn't enough detail perhaps about the Welsh context and we wanted specific modelling of the virus and the epidemiology within Wales.

So it took on -- the group took on specific functions like that. It was also a broader group for considering issues related to science generally.

Q. Was there clarity between the role and the output of the Technical Advisory Cell and the role and output of the Technical Advisory Group?

A. I believe so. They did have different functions. The cell was entirely within the Welsh Government and the group was much broader. But there are terms of reference for both those groups.

Q. And did both of those groups provide advice that you relied upon?

A. I think they would have been summarised in the TAC -- the Technical Advisory Cell briefings.

Q. Moving to look at the advice and information about Covid-19 that you received from the Technical Advisory Cell and other sources in the early stages of the pandemic, you've explained in that second witness statement that you have provided that having seen a SAGE paper from 14 February 2020 you conclude that your understanding in early March as to how the virus was transmitted would have been that the two main modes of transmission were touch, fomites and droplet but airborne transmission was a possibility, particularly following aerosol-generating procedures.

Could you explain what your understanding was at that time of what was meant by "droplet", "aerosol" and "airborne" in that context.

A. So my understanding of the transmission early in the pandemic was that we rapidly realised that it was primarily a respiratory infection.

Q. If I can stop you there, please.

Dr Atherton, I'm asking what you understood by those three terms: "droplet", "aerosol" and "airborne". What was your understanding of what those three terms meant?

A. I was about to try to help you understand that -- I mean, a respiratory infection is by its nature transmissible through airborne transmission. So I see droplets and aerosols as a form of airborne transmission.

Q. So you saw droplet and aerosols both as being indicative of airborne transmission, is that --

A. I believe, yes.

Q. You've also set out that by 5 June a Technical Advisory Cell summary provided to you set out key conclusions of a SAGE report including that there was weak evidence that aerosol transmission may play a role in poorly ventilated environments.

Where you were provided with scientific evidence

that was unclear or uncertain or assessed or described as "weak", what was your approach to providing advice based on that evidence?

A. My advice would always be to acknowledge the strength -- you are talking about myadvice to ministers, for example?

Q. Yes.

A. It would always be to let ministers know what was known but also the strength of the evidence with which we knew it and the uncertainties which would be around that. That would be my normal policy, my normal way of working.

Q. Were you aware of what's been described as the precautionary principle at that early stage in the pandemic?

A. Throughout my career I've worked on the basis of precautionary principle. People have mentioned it and used it. It's a term which I find slightly confusing sometimes in that, as I understand it, there are different formulations of the precautionary principle. But it's one way that we're helped to think about things but it's not the only way that we think about things in public health terms. But of course I'm aware of the precautionary principle if that's what you are asking.

Q. Did that inform your advice or the way that you

formulated advice during the pandemic?
A. It would be one of the ways in which my advice was formulated. It would be one of the considerations I would give to evidence as it became available.
LADY HALLETT: Dr Atherton, as -- you're obviously right, I have heard different definitions of the precautionary principle. Do you have the same understanding as Professor Sir Chris Whitty, which is the precautionary principle applies where there are no downsides to taking a particular course of action? Is that how you interpret the precautionary principle -- or significant downsides?
A. Well, I do, my Lady, and that's one of the difficulties with the precautionary principle. I could give you an example from way beyond Covid but it might take too long but I will if it would help.
LADY HALLETT: Depends on how long.
A. I will do it very quickly.
When I was working in Nova Scotia I was a member of a panel looking at the issue of fracking and the question was whether Nova Scotia should frack, should allow, you know -- the policy environment should allow fracking. And the argument is always made: well, on the precautionary principle, there are downsides to fracking, because you might get earth tremors, you might

get an increase in global warming. But of course the opposite applies in as much as if you don't frack then you end up importing fuel and hydrocarbons from somewhere else at a greater cost. So actually you can use the precautionary principle in both directions. So it doesn't really help you to come to a final decision.
It's useful in your thinking and it was useful in the thinking around Covid but it's not the only principle that you should use.
I agree with Sir Chris I think when he summarised it perhaps as saying that we need to look at evidence about the benefits and the harms and the evidence that sits around those. I find it better -- more helpful to work in that way than purely to think about the precautionary principle. But I think it's always at the back of my mind, yes.
MS NIELD: Thank you, my Lady.
Can we move on now to look at infection prevention and control guidance in Welsh healthcare settings during the pandemic.
Can we go, please, to page 53, paragraph 149 of your first witness statement, please.
You've said that:
"During all phases of the Covid-19 pandemic, health and social care providers in Wales were asked to

adhere to the UK IPC guidance ... issued jointly by [Department of Health and Social Care], Public Health Wales, the Public Health Agency (Northern Ireland), Public Health Scotland, UK Health Security Agency ... and NHS England -- also referred to as the 'UK IPC Cell'."
Is that correct, there was no deviation from the UK IPC cell guidance in healthcare settings in Wales?
A. I don't believe we ever deviated from it, and I think that was quite important, to get consistency across the four nations.
Q. And I think Wales' involvement in the UK IPC cell was through Dr Eleri Davies at Public Health Wales; is that correct?
A. Dr Davies was a member of Public Health Wales, still is -- actually, I think she may have retired, forgive me. But she was, and she subsequently took on the chair of that cell as well.
Q. In your role as Chief Medical Officer, did you consider that it was any part of your role to undertake a review or analysis of whether the IPC guidance and recommendations for PPE measures were suitable or appropriate for healthcare settings in Wales?
A. It's our job to receive the IPC guidelines, to understand them, to disseminate them. It wasn't our

role to second-guess them. And this comes to the question of where we establish expert groups with far more experience than I would have, for example, or any of my -- a member of team would have had, that we would usually follow that advice rather than second-guessing it.
Obviously, if there were controversial areas, as subsequently arose, then we would discuss those with the IPC cell or we would discuss them at the Senior Clinicians Group, but, yes, that's how we worked with the IPC cell. Broadly we accepted their recommendations on the basis that there were experts in there, national and international experts, who were assembling the evidence base as well as they could.
Q. I'm going to move on and ask you about two occasions when there were issues that were raised about the suitability of PPE, particularly that was stipulated in those -- in that IPC guidance.
Were there any occasions where you had concerns about the effectiveness of the IPC guidance in healthcare settings in Wales or the level of PPE that was being specified for healthcare workers?
A. I don't think there were occasions where I had specific concerns but clearly there were concerns being raised elsewhere, which I was not unaware of, I was acutely

aware of in fact, and so managing that interface between the IPC cell and the rest of the system was quite a challenge, I would say.

Q. Perhaps we can come on and look at the first of those incidents to which I think you're probably referring. There was, I think in April of 2020, an occasion when you and the Chief Nursing Officer sent out a joint letter to hospitals in relation to the PPE for cardiopulmonary resuscitation. Do you recall that?

A. I do, yes.

Q. I think at that time there was a divergence between the UK IPC guidance, which indicated that cardiopulmonary resuscitation was not considered to be -- or chest compressions during cardiopulmonary resuscitation was not considered to be an aerosol-generating procedure and therefore full PPE and respiratory protective equipment was not required. And the Resuscitation Council UK were recommending that full PPE with RP should be worn in the absence of clear evidence that CPR was not an aerosol-generating procedure. Do you recall that that was the divergence?

A. You describe the divergence very well.

Q. Can we look, please, at the email chain that you have provided to us around this.

It's INQ000384586.

It's behind tab 51 in your bundle, if that assists.

A. Forgive me. It may take me a little time to get there.

Q. I think we probably don't need to look at the RCUK statement on page 4 because we've summarised that.

A. Can you give me the tab again, please.

Q. It's tab 51.

A. Got it, okay, thank you.

Q. I hope.

A. Yes.

Q. If you could go to page 2, please, of that.

This is an mail from Jean White, the Chief Nursing Officer, to yourself to your deputy, to Gill Richardson, and copying in Andrew Goodall. She is requesting that you discuss the latest statement which has been produced below from the Resuscitation Council.

She says that she has:

"... been told that many of the Health Boards are now rejecting the [Public Health England] [that's the UK] PPE guidance and our suggested compromise of covering the mouth and insisting the boards accept the Resus Council position. I think [Cardiff and Vale] is the latest in a line to go down this route ... I wonder if we should have made a decision to just accept the Resus Council position as best practice for Wales given

the level of distrust now apparent with the PHE PPE guidance."

And she says she would "welcome a professional conversation about this".

So that was the issue that was being proposed by the Chief Nursing Officer, that it would be possible to simply accept the Resuscitation Council's advice on this.

And if we can go to page 1, please, first of all your deputy, Dr Chris Jones, assess that:

"... we cannot control or mediate this standoff between the [Resuscitation Council] and [Public Health England].

"...

"I remain clear our position has to be that we support the PHE guidance informed by NERVTAG advice.

"It is for organisations to consider what advice they wish to adopt."

Then if we can go to the very top of that page, please, Jean says that she has spoken to you, and:

"... we both agree with your advice on this [this is to Chris Jones] and will take no further action."

I'd like to ask why you agreed with your deputy that it was for organisations, that is health boards, to decide what kind of PPE should be used rather than

adopting that proposal of the Chief Nursing Officer to accept the Resuscitation Council's position?

A. Well, I think as the email chain shows, there was a clear divergence of opinion between the Resuscitation Council UK, NERVTAG and the IPC cell. So there was something of an impasse there, both claiming to be based on the best evidence.

Our inclination, of course, as I think we've just been discussing, was to follow the advice of the IPC cell, based on international best practice and the experts they had available.

The compromise that Jean had suggested, I think of covering the mouth, seemed a sensible one, because how can an aerosol escape from a person's mouth if you cover the mouth with cloth? It seems unlikely that aerosols would be able to escape, just on first principles, really.

That clearly didn't satisfy everybody's need and so there was an impasse. There was a very difficult impasse to manage.

The way I think it was managed eventually was to say to health boards: well, if higher grade PPE is available then staff should be allowed, empowered, you know, enabled to use it. But it wasn't a directive that they should use it. As Chris Jones rightly points

out -- well, there are two problems that arise from this discussion. One is that any delay, of course, in CPR when a patient has suffered a cardiac arrest is disastrous, can lead to death and/or -- death or brain damage of course. So any delay was to be avoided. And this really didn't address the issue of what happens when somebody has a cardiac arrest in the community and the issue of people, bystanders, who might be providing CPR who would have access to no PPE essentially.

So that's why it was left to the health boards to decide. It was permissive rather than directive, let's say.

Q. But doesn't that lead to a situation where there's still going to be inconsistency potentially between different local health boards and already a degree of mistrust about the guidance that's being provided? Did you not consider that it was your role, in terms of your professional leadership role, to bring a consistent voice?

A. Well, we did bring a consistent voice: jean and I consistently said we should follow the PPE -- the IPC guidance based on the NERVTAG advice. So we did provide that consistency. But if that doesn't meet everybody's needs and, as we've just been discussing, health boards or autonomous bodies, then providing the reassurance to

staff that they could use additional measures if they risk-assessed the situation and felt it was most appropriate and it was available, then that's fine.

I think what happened as a consequence was that -- I mean, I don't know the details but I think what happened was that health boards did have more PPE equipment on the resuscitation trolleys. And these are, let's not forget, relatively rare events. So the whole issue was quite difficult to manage, the interface was difficult to manage, but it settled down.

Q. What was your view on the position of the Resuscitation Council UK that the absence of high-quality evidence as to whether chest compressions generated aerosols should not be interpreted as an absence of risk, applying the precautionary principle that you enunciated earlier?

A. Can you ask that again, please. Sorry.

Q. So the position of the Resuscitation Council UK that absence of high-quality evidence that chest compressions generated aerosols should not be interpreted as absence of risk, were they not taking a precautionary approach? And what was your views on that?

A. Well, I didn't have a particular view. I recognised that the expert opinion on the opposite side through the NERVTAG and IPC was a balanced view. I didn't see that the application of -- I don't think I considered the

precautionary principle in all of that.

The other problem would be, if you took a purely precautionary principle where would it lead you? Would it lead you to people wearing powered respiratory hoods? You know. So we have to be careful about the precautionary principle again because becoming too precautionary stops the thing you want to happen.

If you say you cannot provide CPR unless you have a certain level of kit, whether that's an FFP3 mask or a powered hood or a HAZMAT suit, you're putting the lives of individuals at risk. And so, on a precautionary basis, if you support what the patient needs, you would say -- you would come to the exact opposite of what you just described.

Q. I think later in the pandemic, in November of 2021, you were involved with another issue that was raised in relation to the PPE specified in the IPC guidance, and this was around the emergence of the more transmissible Omicron variant. Can we look, please, at page 55 of your first witness statement. This is paragraph 158.

You've noted that:

"In November 2021 the UK [Chief Medical Officers] and nursing officers asked the UK IPC cell, then chaired by Dr Eleri Davies to review evidence around the route of transmission."

Dr Eleri Davies provided you with informal updates around the work of the IPC cell.

"This email [that you've included] confirmed that the Cell had discussed the implications of the Omicron variant for the [UK] IPC guidance, and that all member organisations/countries of the cell were represented and a wide-ranging discussion was had. The consensus view of the Cell was that the IPC Guidance as it stood was currently fit for purpose."

And:

"... the Cell considered that current PPE recommendations remained appropriate."

We can take that down, thank you.

What were the concerns of the four Chief Medical Officers at that point? Why is it that you had asked for the PPE aspect of the IPC guidance to be reviewed?

A. I don't remember exactly, but I think it was to do with the fact that there was increasing evidence that Omicron variant was more transmissible. In fact, if we look back, every variant which arose had a little bit more transmissibility and that's how they became the dominant variant.

So it was to do with the transmissibility from person to person. And I think the thinking, the questioning, was whether this represented different

modes of transmission and whether the IPC guidelines were still robust, and that's exactly what we asked the cell to look at. I think the CNOs, the Chief Nursing Officers, were also asking the cell to do the same thing.

Q. I think the focus of the request was whether fluid-resistant surgical masks were still appropriate or whether there should be a move to specifying RPE (respiratory protective equipment). Is that what you recall?

A. That may well -- yes, that may well have been part of the questioning, yes.

Q. Can we get up, please, the email that you have referred to there.

That's INQ000252535.

This was the email sent from Dr Eleri Davies to you on 6 December, and I think, having informed you that the IPC cell had met and discussed this, Dr Davies advises you there that.

"[They] will [be discussing it again] at [the] IPC cell on Wednesday and happy to feed back to Thursday's Senior Leaders group.

"Happy also to meet with you tomorrow as Sue [Hopkins] suggested to discuss further if that helps."

I think the list of key meetings that you've

helpfully provided to the Inquiry indicated that an informal meeting took place between yourself and Public Health Wales on 8 December 2021. The subject was "Omicron variant and IPC guidance". Would that meeting have been with Dr Eleri Davies?

A. I really can't recall but I'm sure it would have been, given the nature of the email. Is there a tab number for that, can I ask?

Q. There is but I wasn't going to suggest that we necessarily get that up.

A. Okay.

Q. That's literally all the information that you have, is the title of the meeting.

But do you have any recollection of Dr Eleri Davies explaining to you the reason for their confirmation that the PPE guidance would remain the same?

A. No, I'm sorry, I can't remember that.

LADY HALLETT: Are you moving to a different topic?

MS NIELD: I am.

LADY HALLETT: As you may remember, Dr Atherton, we break regularly. I shall return at midday.

(11.45 am)

(A short break)

(11.59 am)

MS NIELD: Dr Atherton, nosocomial transmission of Covid-19 in Wales, can we go, please, to page 56, paragraph 159 of your first witness statement. You say that:

"Another source of guidance and oversight of IPC measures was via the Nosocomial Transmission Group ..."

That was established by yourself and the Chief Nursing Officer for Wales in May 2020 with your deputy, Professor Chris Jones, as chair, and the membership of that group was drawn from Welsh Government, Public Health Wales and colleagues from health, social care and professional organisations.

As you considered the Nosocomial Transmission Group to be a source of guidance and oversight of IPC measures, does that mean that you considered that nosocomial infections were an indication of how effective or not IPC measures were in hospitals?

A. Well, of course, we were hugely conscious throughout the pandemic, even from quite early days, that closed settings, including hospitals, were sources where, places where outbreaks could happen.

Your question is did the fact that outbreaks were happening, did that affect our decisions, our views of the IPC? Is that kind of roughly what you're asking?

Q. Yes, perhaps to put it another way: if there were issues with frequent or repeated hospital outbreaks, would that

indicate that either the IPC measures stipulated in the guidance were not being implemented or the measures stipulated were not effective?

A. I don't think it would mean either of those things, really. In hospital settings it's impossible to completely eradicate nosocomial transmission. That was true before the pandemic, it was certainly true, of course, during the pandemic. No matter how good your IPC is, the only way to stop nosocomial transmission in hospitals would be to close the hospital.

So the issue for me was rigorous application of evidence-based policy and the evidence-based policy clearly was coming from the IPC cell and we were working with the health boards to make sure that it was rigorously applied. That, to me, is the way that you should deal with nosocomial transmission. You will never eradicate it but you should reduce it as much as you possibly can.

Q. Wouldn't the way to reduce it be to have effective infection prevention and control measures that were rigorously implemented?

A. That's what I just said.

Q. So does it follow from that then that if there are regular and repeated outbreaks, something has gone wrong with the IPC measures?

A. No, it doesn't.
Q. It may be that it's not possible to eradicate entirely but wouldn't one expect to be able to reduce nosocomial infections?
A. It's the whole purpose of IPC.
Q. Thank you.
The Nosocomial Transmission Group, I think reported to the Minister for Health and Social Services; is that correct?
A. Whether it reported directly, I mean, you'd have to look back at the terms of reference, I am sure you have them I thought it reported through the group that Andrew Goodall chaired, indirectly perhaps, but ultimately, yes to the minister.
Q. It provided ministerial briefings.
And can we look at, please, INQ000396261.
This is behind tab 13 in your bundle if you would like to go to the paper copy, Dr Atherton. This a ministerial briefing dated 15 November 2020, and this paper set out that nosocomial infections had risen across Wales in the previous few weeks in every health board area.
If we could look at the second paragraph, please, it explains that in the week ending 8 November 2020, there were 210 cases of probable or definite

hospital-acquired Covid-19 infections. These represented 3% of all cases diagnosed in that week but 50% of all cases diagnosed in hospitals.
So, in other words, 50% of those Covid infections in hospital were people who had come into hospital for treatment for another condition or health problem and contracted Covid-19 during their stay.
If we can look at the bottom half of that, the lower half of that page, we can see that it states there in the penultimate paragraph:
"The evidence suggests that properly used [I think that should be PPE] limits transmission between staff and patients but that transmission is occurring between patients and between staff."
Was that your understanding of one of the major issues with nosocomial transmission at that point?
A. I think at that point in time it was certainly recognised that there was infection between -- from patient to patient, from staff to staff, and from patients to staff. So Public Health Wales was trying to kind of work out where the balance of those transmissions were. I don't think we ever got fully to the bottom of it. But of course there was also the issue of, you know, people coming in from outside and transmission from the community into hospitals. So all

of that was at play, absolutely.
Q. And then we can see in the following paragraph that one health board had recently found that although staff should be testing positive at a similar rate to their local community, one health board recently found 24% of staff were positive despite only a 1% community prevalence in that area.
I think if we can go to page 6 of the report, please, it's proposed there that asymptomatic NHS staff testing should commence, all patient-facing staff being tested twice weekly. I think that proposal was implemented beginning in hospitals on 14 December 2020, and I think you have noted that the wider roll-out, including in general practice, began on 11 January 2021.
We can take that down, thank you.
Was that programme then that was announced and begun in December of 2020 the first time that there was a national policy of asymptomatic testing of healthcare workers in Wales?
A. I think it was. There had been a pilot of testing in Merthyr Tydfil and I can't remember whether that was only in the community or also included the hospital. So there may have been some piloting really. But at this stage of the pandemic we finally had access to the lateral flow tests which were available in bulk in large

numbers and so testing, asymptomatic testing of large numbers of people, including healthcare workers, became a possibility, yes.
Q. So had the limiting factor in rolling out routine asymptomatic testing been the testing capacity for PCR tests in Wales prior to that point?
A. That was certainly an issue, absolutely, yes.
Q. Can we go, please, to a further update from the Nosocomial Transmission Group.
This is INQ000227307.
It is behind tab 12 in your bundle, Dr Atherton.
A. Tab 12?
Q. Tab 12, please. It's headed "Update on COVID-19 Nosocomial Transmission, the [Welsh Government] Nosocomial Transmission Group and current priorities".
I think there isn't a date, actually, on that report but you have indicated in your witness statement where this is exhibited, that the report was issued on 18 February 2021. So three months after the briefing paper that we just looked at.
We can see on that document on page 1 under the heading "Hospital onset cases" the last two sentences of that paragraph that:
"... in the week ending [14 February 2021], a Wales total of 211 hospital onset cases ... were

reported [representing] 8% of all confirmed COVID-19 cases and 53% of total COVID cases within Welsh hospitals."

So a slight increase on the previous position.

Then if we could go to page 2, please, there's there a graph. This is setting out across Wales the weekly counts of probable and definite nosocomial Covid-19 in Wales, and we can see that the nosocomial infection rates were actually higher in wave 2 towards the end of 2020 than they were in wave 1 in around March and April of 2020.

Looking at that graph, those figures nationally peaked in the week ending 13 December 2020 at 360 cases and they dropped before rising again to around 300 for the week ending 17 January.

If we can go to the graph below, please, this shows nosocomial infection rates by health board and on that document we can see that each health board has been given a different colour line on that graph. We can see that there is considerable variation between the local health boards in terms of both the timing and the size of their hospital outbreaks.

I think the lowest line on that graph is the yellow graph for Powys. I think it's right that there are no general and acute hospitals in the Powys health

board area; is that correct?

A. That's correct, yes.

Q. There are just community hospitals, I think.

A. Correct.

Q. Does that go some way to explaining the lower rates there?

A. I think it explains it entirely.

Q. We can see also at -- very low on the graph, a pink line which occasionally does rise above zero. That is the Velindre trust, and I think Velindre trust does not run any general hospitals but there is a specialist cancer facility within the Velindre trust; is that correct?

A. It's a cancer service, yes.

Q. So that area was supposed to be a Covid-free green zone, was it not?

A. Well, everywhere -- all the hospitals we tried to make as Covid-light as possible. It wasn't possible to make anywhere entirely Covid-free because Covid was circulating in the community at this time -- at these times, I should say, first and second waves of course.

Q. In the general acute hospitals in the other boards there would be red and green zones, is that right, patients would be cohorted according to their Covid status?

A. Not initially. Towards the latter part and -- sorry, what's the date of this, can you remind me?

Q. February 2021.

A. So by this time some hospitals were employing red and green zones and trying to manage the risks in that way, keeping patients who were Covid positive together. That wasn't -- that was a local response, let me say, rather than any kind of national response. It was about hospitals working out their estate and the way that they could segregate patients. Yes.

Q. So if we can look at specifically Velindre cancer specialist hospital, was the process there not that all patients were tested for Covid before they were admitted to the hospital?

A. I think by that time that was happening.

Q. So does that tend to indicate -- or was the Nosocomial Transmission Group able to identify whether those hospital-acquired cases, albeit they're in low numbers, the hospital-acquired cases at Velindre hospital came from patient-to-patient transmission or from staff infecting patients?

A. I don't think the paper elucidates that issue, correct me if I'm wrong, if somewhere further in it, it does.

Q. We can also see in the middle of that graph a very noticeable spike for Betsi Cadwaladr local health board in around the summer of 2020 when cases are low in the other health boards. Were the Nosocomial Transmission

Group able to establish the reason for that isolated spike when hospital outbreaks in the rest of the Wales were very low?

A. Again, I don't know whether that's covered later in this paper or not. I wasn't a member of the group, so I don't know.

Q. If we can go to page 4 of this document, please, I think a number of priorities are indicated there, the first amongst which is "Develop[ing] a patient testing framework". By this time, in February 2021, was there no such patient testing framework in place for the hospitals in Wales?

A. Well, we did bring in a patient testing framework. The testing programme was run through a thing called TTP, Test, Trace, Protect. So there was a group working within Welsh Government which was working on the policy for testing and that would be for testing patients, for testing members of the community, for testing healthcare workers. So there was a group developing the framework but I couldn't tell you from memory exactly where that was in -- did you say January 2020?

Q. This is February 2021.

A. February 2021?

Q. Aside from the work of Test, Trace, Protect --

A. Yes.

Q. -- was there not a framework for patient testing as part of the infection prevention and control measures in place for healthcare workers?

A. I believe there was. I believe there was a policy of testing patients prior to admission, and I think retesting ten days after admission, and that was a way in which, from the previous graphs, you could try to distinguish, not wholly, but try to distinguish between patients who had become infected in the community and then came into hospitals, from patients who were contracting infection within the hospital.

So the short answer is I believe there was.

Q. So if there was already a testing framework in place, why was that being proposed in February of 2021 in this document, if it was already in existence?

A. Well, I can't tell you other than to read the sentence which says that there's a revised testing strategy and maybe it was about updating the patient testing framework, but that's all I can surmise from what I see in front of me.

Q. Thank you.

Could we go to page 7 of that document, please. The top point there:

"Continue to provide robust advice on ... (PPE) in the context of new variants ...

"[Healthcare workers] have expressed concern about the adequacy of PPE following the discovery of the new more transmissible variants of COVID-19.

"The NTG will continue to address concerns raised by [healthcare workers] and engage with colleagues from the UK IP&C COVID-19 Guidance Cell to ensure the provision of robust, evidence-based advice."

Is this a reference to the occasion that we considered prior to the break, is this why the four Chief Medical Officers had asked the UK IPC cell to review the PPE specified in the IPC guidance, the PPE specified?

A. The two may be related but whether they were directly related or one was a consequence of the other I couldn't say. I think, yes, there were still rumblings about PPE and professional bodies were raising questions, quite reasonably, and so I think the approach of the Nosocomial Transmission Group quite rightly was to try to engage with the system to try to understand and allay some of those fears but also to work with the IPC cell to make sure things were up to date.

Q. So far as you are aware, did the Nosocomial Transmission Group ever advise that the PPE specified in the UK IPC guidance should change or that healthcare workers in Wales should have access to a higher level of PPE than

that specified in the UK guidance?

A. I don't believe so.

Q. We can take that down now, thank you, Lawrence.

There was an internal audit service report on the NTG dated 1 September 2021 which you have provided to the Inquiry.

Can we look, please, at INQ000022598, page 3, please.

This is at tab 39 of your bundle if you would like to go to the hard copy, Dr Atherton.

This service report noted that the Welsh Government had issued guidance throughout the pandemic to all trusts and boards and at paragraph 3.6 we can see:

"We considered what further actions the [Welsh Government] might take to ensure the guidance issued is having the desired effect."

The final sentence says:

"The NTG ... routinely monitors rates of transmission, as discussed below, but not with the expectation there is a direct correlation between the guidance issued and lower infection rates."

Could you explain that last sentence, please.

A. I could try. I mean, I think it reflects what I was just describing to you, really, which is that it's the

job of IPC to reduce transmission rates as much as possible but you can't direct -- you can't eliminate the issue. So I think it's really just a reiteration of what we just discussed, to me, just reading it there.

Q. So the Welsh Government NTG were responding to issues of nosocomial infection rates in Wales by issuing further guidance about the importance of IPC measures but did not expect there to be any correlation between that guidance and lower rates of infection? This isn't talking about eliminating nosocomial infection but reducing it. So what was the purpose of issuing further guidance if there was no expectation that that was going to make any difference?

A. Well, it's an unusual line, I agree. You know, it's in the internal audit report. You'd have to ask the internal audit people exactly what they meant by it.

But certainly the task of the NTG -- sorry, the role of IPC absolutely is to reduce infection rates, to reduce nosocomial infection. So to that degree I would disagree with the internal auditors in that comment. But I don't know what they had in mind when they wrote it.

Q. I think this is the internal auditors saying what the expectation is of the Nosocomial Transmission Group rather than their own expectation.

A. Yes, it is, yes. It's their interpretation of what they think the NTG believes.
Q. Thank you.
The Nosocomial Transmission Group was stood down, you say in your statement, on 28 March 2022. In the time that it was active from May 2020 to that date, did the Nosocomial Transmission Group identify what was the primary cause or causes of these recurrent hospital outbreaks in Wales?
A. It was the transmission of virus, as we discussed, between patients, between members of staff, from patients to members of staff and possibly to some degree vice versa. I don't think that the NTG was able to disentangle that. I think that there has been work at UK level to try to understand that better but I don't think we fully understand it. But the prime purpose of the NTG was to reduce -- to monitor and reduce the level of nosocomial transmission.
Q. The internal audit report that we saw was dated 1 September 2021. By the time that the Nosocomial Transmission Group was stood down at the end of March 2022, did it appear that it had been successful in reducing the number or severity of hospital outbreaks of Covid in Wales?
A. You will never know without applying the counterfactual

what would have happened if the Nosocomial Transmission Group had not been active. I would suggest things would have been much worse. There would have been much less advice and support to the health boards, who -- let's remember, the health boards were responsible for managing the risk around nosocomial transmission, not the Welsh Government. The Nosocomial Transmission Group did support them in all of that work. If it hadn't been there, would things have been worse? I suspect it would.
Q. Do you know if any final report was issued by the Nosocomial Transmission Group at the point it was stood down?
I can say that one doesn't appear in your witness statement.
A. I don't recall one.
Q. Thank you.
In relation to effective IPC measures, I would like to ask you about an observation in the Chief Medical Officer's technical report. That's the technical report of the four Chief Medical Officers to which I think you contributed, Dr Atherton. I don't think we need to get this up but it's at page 363 of that report.
It indicated that the most effective IPC measures

for preventing transmission to patients were: firstly, testing patients on admission; secondly, increasing space between beds; and thirdly, decreasing hospital occupancy.
Did you agree first of all with those conclusions that were in the report?
A. Yes. The report is jointly issued by the CMOs so I'm sure it's correct.
Q. To your knowledge, in Wales were there practical difficulties in reconfiguring rooms and decreasing occupancy which proved a barrier to implementing those steps in Wales?
A. Yes. It's widely understood in Wales that the estate is not as modern or as adaptable as it needs to be. A lot of our hospitals are very old. They're from the 60s and 70s. Achieving good levels of patient care and particularly IPC infection -- following IPC guidance is a real challenge for many of our hospitals. So absolutely, yes.
Q. On reflection, and perhaps with the benefit of the hindsight, do you consider that sufficient steps were taken to try to implement those aspects of IPC guidance and to address nosocomial spread between patients in Wales?
A. So my main route of knowledge of that, to answer your

question, would be through medical directors who were bending over backwards to try to manage, reconfigure the space, meet the demands of patients coming in through successive waves -- a very challenging time for them. But they were all working with their estate colleagues to try very hard to achieve those aims. The estate worked against us in terms of its age and the infrastructure that we had available.
Q. In terms of the estate, were you aware of any planning or discussion around the possibility of other interventions such as the use of air filtration or improving ventilation systems?
A. I think all hospitals were looking at how they could provide better ventilation. I wasn't working directly with them or involved in discussions with the hospital engineers, but there was -- by the middle of 2020 there was a widespread recognition that because this was an airborne transmission through respiratory -- a respiratory infection that better ventilation was a part of the IPC, and in fact it features quite significantly in the IPC guidelines.
So there were efforts to try to improve, but, again, the estate didn't always make that easy.
Q. Were you aware of any steps that were taken or measures that were proposed specifically in relation to patients

who had been identified as clinically extremely vulnerable, for example, prioritising those patients for single occupancy rooms?

A. I don't know whether that happened in health boards. I do know that there was very close consideration of providing surgical masks to those patients when they were coming into hospital to support them.

Q. Can we move on, please, to the shielding programme in Wales, having touched very briefly on the clinically extremely vulnerable.

I think it's right that the shielding plans for the UK were developed by the four-nation Chief Medical Officers working together on that plan or that programme; is that right?

A. There was a kind of clinical -- sorry, there's a clinical group who worked up the processes around that but the four Chief Medical Officers asked for that work and signed it off, I think, yes.

Q. I think it's right that through that process, two lists of conditions, health conditions were formulated. One was those conditions giving rise to what was considered to be clinical vulnerability and those were: anyone over the age of 70 and then those under the age of 70 with certain specified health conditions such as diabetes, mild to moderate asthma and other respiratory diseases

and chronic diseases of the heart, liver, kidneys, some neurological conditions, those who were seriously overweight and pregnant women. That was the list of conditions giving rise to clinical vulnerability; I think that's right, isn't it?

A. I think that was the starting point when the shielding programme was first envisaged.

Q. I don't think these were people who were advised to shield but those who had been advised simply to follow stringently the social distancing advice that was given to the general population?

A. You're right, there were broadly three groups: the general population; the more vulnerable people, broadly people who received the flu jab, that was as derived from first principles, really, thinking that they would be at increased risk; and then the clinically extremely vulnerable, CEV, clinically extremely vulnerable, who had specific conditions which would render them particularly likely to suffer serious harm or death if they became infected.

Q. I think you set out in your witness statement that on 17 March the Welsh Government issued guidance on social distancing and advised the clinically vulnerable group to be very stringent in following those social distancing measures.

Having issued that guidance for the clinically vulnerable, I don't think the Welsh Government issued any further guidance to that group of patients; is that right?

A. You could well be right.

Q. And then subsequently, I think on 18 March, the list of conditions identifying the clinically extremely vulnerable was cleared by the four Chief Medical Officers, and that included solid organ transplant recipients, people with specific cancers, severe respiratory conditions, rare diseases and inborn errors of metabolism that significantly increased the risk of infection, people on immunosuppressant therapies, and pregnant women with significant congenital heart disease.

I think it may follow from your previous answer, but did you have input directly in formulating the list of health conditions for the clinically vulnerable and clinically extremely vulnerable?

A. No, I didn't.

Q. During the process of discussing who should be on that clinically extremely vulnerable list, do you know whether any disabilities were considered as a criterion that should qualify for clinically extremely vulnerable?

A. Well, "disability" is a very broad term.

Q. Were there any specific disabilities that were considered?

A. Not initially perhaps but in later phases people with Down's syndrome were given specific consideration.

Q. I think that was on 30 September 2020 as a result of the work that had been done on QCovid. I think that was Sir Chris Whitty's work on QCovid. It was agreed between the four UK Chief Medical Officers that patients over 18 with Down's syndrome and, indeed, chronic kidney disease should be added to the shielded patient list?

A. If I may, it was slightly more complicated than that. People with Down's syndrome, adults with Down's syndrome were not initially on the list because there wasn't an understanding that they were at particular risk. And the issue came back twice actually to the clinical panel which was led by Dame Jenny Harries, and I can't remember why it came back the first time, I think in June or July it came back, and they looked at it -- it probably came about because we were being asked by patient representative groups to look at it, and in June there was no particular evidence that people in those or people with Down's syndrome had a higher level of mortality. So at that point the decision was not to include them.

Then it came back a second time because there was

further published evidence in one of the journals that there was actually an increased risk of harm and death in people with Down's syndrome. So probably by August or September it came back the second time through the clinical panel which made a recommendation to the CMOs that people with Down's syndrome should be included on the shielding list and at that point they were.

Q. Can I ask you this: once that decision had been made on 30 September 2020, were adults with Down's syndrome in Wales contacted about the decision to include them on the shielded patient list?

A. They were.

Q. Thank you.

Do you know when that happened?

A. I don't off the top of my head, no.

Q. Thank you.

So if we can go back, please, to that initial stage in March of 2020 when there was some delineation of the different health conditions that would be considered to give rise to clinical extreme vulnerability, were you involved in the decision-making to delineate between those two groups and to advise the extremely vulnerable to shield but not the clinically vulnerable?

A. In the decision, yes. The broad proposals had been

drawn up, as I say, from first principles. Sir Chris Whitty I think had done a think piece on it. We were all concerned about specific groups in the population. Remember, we didn't know an awful lot about Covid or the impact it was going to have at that time but we had seen with pandemic flu, for example, that specific groups were more vulnerable and so there was thinking about -- and recognising that the population had no immunity, we were thinking about, well, what could we do? The original term was "cocooning", the idea was to cocoon people, and that then morphed into the terminology of shielding.

So yes, I think these came to the four CMOs, we agreed it was a good idea, and a clinical panel then worked up the details.

Q. Can I ask you about this distinction between the clinically extremely vulnerable who were advised to shield and the clinically vulnerable who had been identified and told by letter that they were at additional risk of developing severe complications from Covid-19 but they were not advised to shield. Did you have any concerns that that group were at additional risk but were not given the protection, as it were, of the shielding programme?

A. Well, there were some additional risks, quite clearly,

otherwise we wouldn't have written to them. But the numbers would have been so enormous that you couldn't possibly -- well, it would be like asking -- you might as well ask the whole population to shield which is essentially what we did when we moved into lockdown.

Q. Were economic considerations part of that decision that it would not be workable to ask?

A. I don't remember them being discussed at CMOs group at all, no.

Q. Once the list of conditions of the clinically extremely vulnerable had been finalised on 18 March, then the patients in Wales with those conditions had to be identified and contacted with the shielding advice and I think you co-ordinated that operation as Chief Medical Officer; is that right?

A. Well, I didn't co-ordinate it personally, you will understand, but a group that worked within my directorate was set up to do the really quite difficult technical job of identifying those patients and then writing to them and keeping in contact with them.

Q. I think that process of identifying the patients was a two-phase process; is that right?

A. Well, it was two-phase in as much as initially the patient groups were -- yes, were defined, and then there was a second phase when the QCovid that you described,

the QCovid -- came to fruition, yes.

Q. So was QCovid used in Wales then to identify patients on the shielded patient list?

A. Indirectly. The same criteria were applied in Wales but what we didn't have in Wales was an IT system which could very rapidly identify those people. So there was a huge amount of work that had to be done by digital healthcare Wales to try to marry up the IT infrastructure, the databases, the different databases to identify those patients.

So in a very -- it was a technical process which was very elaborate and way beyond my understanding but they did manage to do that.

Now, having said that, there was always a recognition that there would be some patients who were missed, some patients who were included but shouldn't have been included. So it was a bit like any screening programme that people were -- there were false positives and false negatives, but they did the best they could, I think, to interrogate the databases and make them work together.

Q. I think you have identified in your witness statement something in the region of 12 different databases that had to be interrogated --

A. Yes.

Q. -- in order to identify those patients --
A. Yes.
Q. -- with those conditions.
If there was, in a future pandemic, again a decision to undertake a shielding programme and to identify a particular cohort of patients, do you consider that the data systems are now in place in Wales to enable that to be done more quickly than in 2020?
A. No, I don't, if I'm honest. I don't. I think there's a huge job in terms of improving the digital connectedness of the various databases that we hold. We are behind the curve in Wales on digital records. There's a huge effort to try to improve that but we are behind. So I think it's absolutely the case that we need to strengthen those systems.
Q. And are any steps being taken in that regard?
A. There is a Chief Digital Officer within Welsh Government. There is a counterpart in the NHS Executive that we've just described. We do have -- we've relatively recently, by which I mean a couple of years ago, reorganised our digital support at Welsh Government level through digital healthcare Wales. So there's a huge amount going on and work with the health boards but --
Q. Is anything specific happening to try to align those

different --
A. No, that's a great question. I mean, the -- I think for a future pandemic we need to have a much simpler way of identifying who are the vulnerable. Of course, in a future pandemic the vulnerabilities may be different. It may be a different group.
But we need better marrying up of the digital infrastructure to allow that to happen, but something specific to future pandemics would, I think, be very useful.
Q. Is there also an issue about primary care systems not talking to one another and also not being compatible with secondary care database systems?
A. There is. Compatibility across primary and community care is a problem. There's also very significant issues around personal data and the use of personalised data within the NHS, which we continue to grapple with. I mean, patients have to give licence, they have to give agreement that their data can be used in a certain way. So all of that absolutely needs to be worked out.
I don't think that's specific to Wales, I think that's an issue across the piece, to be honest.
Q. Thank you.
Can we look please briefly that shielding letter that was sent in your name on 24 March 2020. This was

the letter sent to the clinically extremely vulnerable advising them not to leave their house for at least 12 weeks -- we know, I think, that that 12-week period was extended until August ultimately -- to strictly avoid contact with anyone with Covid-19 symptoms.
Did you have any concerns about the potential effects of this on the clinically extremely vulnerable in terms of the potential for social isolation?
A. I think it was very high in our minds that this was not an easy thing to ask anybody to do, to remain isolated from society as much as possible, absolutely.
Q. Did you take any steps to address that risk?
A. The main steps I took personally were to make sure that we continued to correspond, to contact with these people. Obviously there was support that was put in around the clinically extremely vulnerable in terms of access to services, access to primary care, access to food deliveries, to pharmaceutical supplies, et cetera. So there was some things in that space, yes.
Q. Thank you.
Can we look at page 2 of that letter, please.
This explains at number 1, the bottom of that page, that visits from carers or healthcare workers would continue as normal. Clearly people who had been identified as clinically extremely vulnerable were going

to have greater healthcare needs than the rest of the population. And it explained there, in the second line:
"All carers or support workers must wash their hands with soap and warm water for 20 seconds when they enter your home and often while they are in your home."
There was certainly nothing in that letter about PPE or other IPC measures that could protect shielding patients from the risk of infection by healthcare workers or carers coming to visit them in their home. Did that omission, in your view, expose the clinically extremely vulnerable to a foreseeable and avoidable risk?
A. Have you got the tab number for it, please?
Q. It's tab 44 --
A. Thank you.
Q. -- in your bundle, and it's the second page of the letter.
A. So, yes, looking back, would it have been good to include something like that? Certainly supplies of PPE were being provided through councils to help -- to social care workers at that time. With hindsight it would have been a good idea to include it.
Q. So do you think that the effectiveness of the shielding programme would have been improved by explicitly addressing the risk of infection from healthcare workers

and including some measures to mitigate that risk?
A. It may well have done, and whether they were included in subsequent advice I don't know. This, of course, was by 24 March, which was really quite -- still quite early on. But, yes, I would agree with your point.
Q. Thank you.

I think we can take that down now, thank you, Lawrence.

The shielding programme in Wales I think diverged from the other nations of the UK in the summer of 2020 when the clinically extremely vulnerable in Wales were advised to shield until 16 August, as originally notified, and the programme in the other nations of UK was paused from 31 July.

You've explained that your advice to the minister to align with the other nations was rejected by the Welsh health minister, partially because of concerns about disability rights groups and other advocates for the shielding and also the minister's understanding that some people had felt abandoned and not liberated by being taken out of shielding.

I would like to ask whether the minister's -- what your view was of the minister's decision in July of 2020 to continue to advise them to shield.
A. Well, I was entirely comfortable with the decisions that

ministers make. Of course I was. The background to that, though, was that originally my advice to pause the shielding at exactly the same time as the other nations was to avoid that divergence, which we know causes confusion and alarm. So that was the basis of my advice.

But in the short-term before that I think, I'd been to a meeting of the -- which a different minister, minister for social policy, I can't remember which minister, a different minister, not a health minister, was chairing -- of the disability equality group, and we'd heard very loud and clear from disabled representatives -- sorry, not representatives of disabled but representatives of disabled groups in that forum that that commitment had been given to extend the screening to -- by an additional two weeks. And so there was a very clear steer through that forum.

I think that is what probably influenced the First Minister in his decision-making. But your question, you know, was -- your question was what did I think about the decision. Are you asking was I angry because there was a variance? No, of course not. I understood it absolutely.
Q. I think after shielding was paused in Wales from 16 August 2020, you also wrote out again to advise those

on the shielded patient list to take extra care during periods of high community infection rates. Was the shielding programme restarted again at any point during the pandemic after 16 August 2020?
A. No, I don't think it was. I think when we got into possibly the Omicron wave, we contacted people to advise them not to fully shield but that it wouldn't have been sensible to go to -- no, I'm wrong. It wasn't the Omicron, it was -- it was Christmas. It was the Christmas of 2020 wave, the second wave, that we advised people not to go to work or to school but to remain at home. So it wasn't full shielding.
Q. There wasn't a formal restarting of the shielding programme?
A. No. No, indeed not.
Q. Thank you. I think it's right that the Welsh Government itself did not undertake any assessment of the effectiveness of the shielding programme in Wales or the impact of shielding on the clinically extremely vulnerable, although it did facilitate some research into that led by Professor Helen Snooks at Cardiff University, and I would like to ask you about the report that Professor Snooks has provided to this Inquiry, which has been provided, I think, to you.

I'd like to ask you about your views of

Professor Snooks' conclusions at paragraph 146 and 148 of that report as to the effectiveness of the shielding programme. These are the conclusions of --
A. Tab number, if I may? Oh, you are not putting it up. That's okay. I can listen.
Q. "There is no evidence" -- this is Professor Snooks' conclusion:

"There is no evidence of overall reductions in Covid-19 infection associated with shielding ... There is evidence that hospital acquired infection was higher in the shielded group. As the mechanism for protecting [clinically extremely vulnerable] people from serious harm of death during the pandemic is to avoid infection, these results cast doubt on the effectiveness of the shielding policy."

At paragraph 148:

"There is little high-quality evidence on the impact of shielding on mortality but those researchers that have investigated this have not found consistent or sustained effects ... Although some uncertainty remains, with findings from several studies -- using different approaches -- showing increased infections, mortality and Covid-19-related mortality associated with shielding, we conclude that shielding did not have the protective effect that was hoped for."

I'd like to ask for your views on those conclusions as the Chief Medical Officer who had responsibility for some of the oversight of the shielding programme in Wales.

A. Yes, thank you. I mean, it's an interesting finding. Obviously it's something that we need to give careful consideration to in terms of in any -- the question as to whether in any future pandemic shielding would be an appropriate tool to use.

It is a rather definitive statement, you know, that Professor Snooks is making. I suspect that there's more evaluation, more evidence, that needs to come to bear and that needs to be consolidated in a body of evidence to inform future planning.

What I can say is, you know, the individuals -- some individuals who I've spoken to who were shielding did feel supported and they valued that. So maybe there's a question of mortality which absolutely needs to be worked through, but there's a question also about how we support the most vulnerable people in our communities and if there are other ways that the Inquiry can identify to support those people through very difficult times, then that would be a splendid thing to have as a recommendation. But I can't off the top of my head think what they are.

So I accept the report but it's only one report. It's not -- I don't think it should be as definitively stated as it is that it had no impact in terms of mortality, and it probably had other impacts in terms of people feeling supported and enabled.

Q. Thank you.

Can we move on now, please, to a different topic: the impact of Covid-19 and inequalities and the exacerbation of inequalities during the pandemic.

You've set out in your witness statement the four harms of the pandemic which had been articulated, I think, by Sir Chris Whitty, and these were taken into account, you say, when advising the Welsh Government.

Those hams included: direct harm from Covid-19; indirect harms if services became overwhelmed; harms from non-Covid illness if medical services were not accessed; and socio-economic harms from the imposition of pandemic restrictions.

Did direct harm from Covid include at any point the impact of Long Covid?

A. Yes.

Q. And at what point did you become aware of the impact of Long Covid in terms of providing your advice to the minister?

A. Oh, I don't think there's any particular point I could

say I became aware that there was an issue with Long Covid, but relatively early on there had been a recognition that viruses can lead to -- the viruses such as coronavirus can lead to post-viral syndromes, and I think a group was set up in Welsh Government to start to consider that. I wasn't directly involved with that.

Q. Can I ask you this then, Dr Atherton: once you were aware of at least the potential for long-term consequences, how did you factor that potential harm in to your advice to the minister?

A. I think it's fair to say that in the very early days of the pandemic it wasn't top of the mind. It wouldn't have been, and I don't think it should have been, because we were trying to work out how to reduce infections to a level which would keep people alive, stop people dying, and stop the hospitals becoming overloaded. That was absolutely the priority in the early days.

In later times, say, from -- I don't know -- roughly, say, September/October onwards perhaps, when we got into the pause between the first and the second wave, and at that time we were starting to get stories of people who were having long-term sequelae of the infection. We didn't know an awful lot about Long Covid

at that point. Of course, we don't know an awful lot about it now; there's still a lot more we need to learn.

So from that point, the consequences would have been factored in certainly through the TAC advice that was coming through.

Q. Thank you.

A. I do remember them reflecting on that but, as the pandemic unfolded, increasingly that became a concern.

Q. Thank you.

I think a fifth harm of Covid or the pandemic was added by the tactical advice group in July of 2021, and this was focused on harm due to Covid creating or exacerbating inequalities in society.

Can I ask you this: prior to July 2021, had a consideration of health inequalities and their potential exacerbation informed the advice that you provided to the Welsh Government or to the healthcare system in Wales?

A. Yes, it absolutely had. The adding -- the addition of the fifth harm, it was recommended through TAC -- obviously, the ministers signed up to that. Ministers in Wales are very focused on tackling inequalities and reducing inequalities.

So two things I should say. One is, really from early days in the pandemic, we had an economic and

social subgroup of the Technical Advisory Cell -- I think it was, yes, a subgroup of the cell and that was focused very much on economic harms to people and very much also on the inequalities and the impacts on particularly more marginalised people in Wales.

Then the other thing I would add is that throughout all the advice I gave to ministers, I was conscious that the impact of the pandemic was not falling equally on the whole of society.

It was -- there were different groups, of course. We can talk about black, Asian, minority ethnic groups bearing a heavier burden. I was very concerned about socio-economic groups who were really facing the brunt of this. I was really worried at one point, at several points within the pandemic, about migrant workers and people living in really quite difficult, straitened circumstances. There were individual groups -- such as taxi drivers -- again, low socio-economic status relatively, who had specific needs.

So we tried to include the information we were getting on all of these groups into the advice we were giving through to ministers and we tried to find ways of ameliorating that harm, so that the poorest, the people being most disadvantaged by Covid were given the additional support that they needed.

Q. I think you presented a paper to the Executive Director Team in June of 2020 called "Covid-19 and Health Inequalities". I don't think we need to get it up. It is behind tab 20 in your bundle.

But I think that that paper identified the sort of inequalities that you have set out now, both by socio-economic position and in terms of a greater impact on black and minority ethnic communities. And I think there was also a report on the impact of Covid on black and minority ethnic communities produced by the First Minister's advisory group. I don't think your office had direct input into that report; is that right?

A. Well, one of my team who was a member of that panel that looked at that, Heather Payne, a very talented paediatrician who worked with us -- also led the MEAG work, the ethical work -- and she was closely involved in Judge Ray Singh's panel and also in the subgroup that worked on developing a risk assessment tool for health workers.

So we had some involvement but I wasn't personally directly involved, you are correct.

Q. Can I ask you this: various reports presented the data on the unequal impact of Covid-19 and identified some of those issues in relation to inequalities for various groups in Wales. Did you identify any specific steps to

be taken either by the Welsh Government or NHS bodies to try to mitigate those risks and avoid the exacerbation of inequalities?

A. Well, I think, yes, following on from my previous answer really. You know, when we became aware of specific issues affecting specific groups, we tried to find ways to solve it.

Q. Can you give us some examples?

A. Yes, of course I can.

We had issues when vaccines became available. We had issues with low uptake in some communities, some of our Asian communities in particular, and so the First Minister asked -- we worked very closely with our colleagues in BAPIO (that's the British Association of Physicians of Indian Origin), a very, very supportive group in Wales, and we set up specific centres in places where their communities could easily access information and get the vaccines.

I talked about taxi drivers. I met with the taxi driver associations and had a long conversation with them about how they could protect themselves, you know, given that they're driving around in a vehicle with people who might potentially have Covid, and that led to Welsh Government putting in screens in the taxi cabs, as an example. So there are micro-examples like that.

Q. But if I could focus on the healthcare system specifically rather than wider steps, one of the recommendations in the First Minister's Advisory Group report was to take immediate action on the quality of recording ethnicity data in health and social care services.

Do you know if that was done; whether there had been any steps to improve data collection?

A. Yes, I think it was done. I think there is -- there was an extension, I think, of mortality data collection to address that issue. I think we talked with ONS (the Office for National Statistics) about that and I think that did become available through the ONS.

Q. I'm not asking about the broader data that's collected by the Office for National Statistics but in terms of the data, the ethnicity coding in hospitals, in primary care, so within the NHS in Wales, were any steps taken to improve collection of ethnicity data?

A. I'm sorry, I can't remember. I can't help you on that.

Q. Thank you.

You mentioned the risk assessment tool that was developed and that, I think, particularly had regard to black and minority ethnic healthcare workers having increased risks.

Do you know whether it was mandatory for the NHS

bodies in Wales to ensure that all healthcare workers were risk assessed using that tool?
A. I don't recall it being mandatory, but certainly the tool was made available and widely used by health boards and welcomed by them. But I don't remember it being --
Q. Was that use monitored by the Welsh Government? Did the Welsh Government collect any information from the health boards?
A. I don't believe so.
MS NIELD: Thank you.
My Lady, I wonder if that's a good point.
LADY HALLETT: Certainly. 2.00, please.
(1.03 pm)
(Luncheon Adjournment)
(2.00 pm)
MS NIELD: Just two more topics, if we may, both of which relate to ethical issues in clinical decision-making during the pandemic, and the first of those concerns a clinical prioritisation tool.
Did you consider that if at some point in the pandemic demand exceeded critical care capacity that clinicians would need a national decision-making tool with clear criteria to apply to ensure that those decisions were based on an agreed approach and consistent across Wales?

Q. I think that as was in March 2020, does that --
A. Quite likely, quite likely.
Q. Was that taken forward?
A. In Wales I think what happened was that the Welsh clinicians were engaged with that work and they obviously knew that that work was going on and so the Welsh Intensive Care Society actually produced a document which it circulated to the system which provided advice should we get into that position. It was trying to prepare the system for if we reached that unfortunate position where we couldn't meet the needs of the population.
Q. I think that was the decision-making tool that was also produced with the Wales Critical Care and Trauma Network.
A. Exactly. Yes, it was.
Q. Perhaps we can have a look at that document, please. It's INQ000338460.
It's behind tab 46, I hope, in your bundle, Dr Atherton, if we need to look at it.
The "Wales Critical Care and Trauma Network", is that an NHS Wales body? What's the status of that organisation?
A. Sorry, the Welsh --
Q. The Welsh -- we can see that its badged here, NHS,

A. Yes, that was a material consideration for us. You will remember back in the days, late February early March, we were looking at what was that happening in Italy and watching the difficulties that hospitals systems were experiencing there and there was a real visceral fear that we would get into that same position in the UK and in Wales. So there was some thinking about what would we do if we reached that point and how would we make sure that people had access to services, how would we prioritise care for people if we reached that point where the system could no longer cope with the demands that were placed on it.
Q. And did the Welsh Government in fact produce a decision-making tool to assist clinicians in the event that they needed to make those kind of prioritisation decisions?
A. No, it didn't, but the Welsh Intensive Care Society produced one.
Just to go back a bit, there were discussions at the four nations I think through the Senior Clinicians Group about what we would do and there was some work which was initiated by intensive care leads at UK level to develop a decision-making tool to help with that issue should it arise. So there was some work that happened at UK level --

"Wales Critical Care and Trauma Network". Is that part of the NHS bodies?
A. It's not a body, a formal body in its own right, but it's a pulling together of critical care leads from across the different health boards to provide leadership. We have a number of networks in Wales. This would be one of them, yes.
Q. Thank you.
We can see that that's dated 13 April 2020.
If we can go to page 5 of that document, please, this is the tool itself and we see that there are four numbered factors to take into account "Assessment of critical care benefit and risk". Number 1 is age, with an arrow pointing from age below 50 to above 80; and then number 2, a clinical frailty scale going from very fit to terminally ill; and then number 3, a comorbidity box that lists a number of conditions with empty boxes next to them, tick boxes; and number 4, female and male with the arrow pointing towards "male".
Below that, "critical care escalation":
"Unless patient with capacity declines for full escalation where necessary."
Then:
"May benefit from critical care admission -- consider discussion."

And then:

"Less likely to benefit from critical care admission."

So we can see that the clinical frailty scale is included there but not with a numerical scoring system; is that right?

A. Correct, yes.

Q. I think by email of 10 April 2020 this tool was circulated to you and at that time I think it did include a numerical scoring system. Do you recall that?

A. I do recall it very well, and can I clarify as well. You know I referred to the work that was done at UK level which did come back to the Senior Clinicians Group and that did have a scoring system on it and when it came back we recognised that it was not appropriate and so it was never agreed at a UK level. I think the same discussion partly played out in Wales.

I think you're right that there was a version which had a scoring system and it was felt that that was an inappropriate thing to have on a document of this nature.

Q. What was the problem with having -- or perhaps I can put it another way. Why was it appropriate to have this clinical frailty scale set out but without the numbers? How did removing the numbers from this render it

appropriate?

A. Well, the problem with the scoring system was it was viewed as being too medicalised. There were concerns which were expressed -- because there was quite a wide consultation at UK level on the document but quite late on there were concerns expressed, particularly by charities and bodies representing disabled people, that the CFS, the clinical frailty score, by itself was -- could lead to -- you can't be too objective with it, it should be regarded as a subjective thing, and that the way that a treating clinician views a person's health and the value that that person places on their health isn't necessarily the same value that a person would place on their health.

So it became highly problematic and on that basis we never approved at the four nations level the use of a scoring system.

Q. If we can come back to this document --

A. I'm about to. So what this document I think very sensibly does, and you need to read it of course in its entirety because I felt that this was an excellent communication from the lead clinicians here into the system, but they made it extremely clear that both the tool here, the appendix 1, the tool -- there it is in black and white at the top: "this tool should not be

used in isolation and must be read in conjunction with the narrative". And the narrative explains that individualised decision-making is absolutely what we need to achieve.

So as a tool to assist in that process I think this was a very useful thing but on its own, certainly with a scoring system, a numerical scoring system, it was seen as not appropriate.

Q. There's still an arrow going from the bottom of the clinical frailty scale to the top of the clinical frailty scale. So were clinicians not taking into account exactly the same factors, just without a numerical scoring system?

A. These are all things to think about. So the arrow also applies to the less than 50 to the over 50. All it's saying is that the risk of intensive care increases as you go up that -- up the arrows and the benefits decrease. That's all it's saying.

So it's helping -- it's intended to help clinicians decide who can best benefit from intensive care facilities. Something that they have to decide on a daily basis within or without the Covid issue.

Q. Were you made aware during the pandemic of any incidence of individuals being denied escalation in their care simply due to their age -- in Wales?

A. Denied ...

Q. Escalation of care --

A. No.

Q. -- due to their age?

A. No, I wasn't, no.

Q. Was this tool in this final form without the numerical scoring system, was this approved by the Welsh Government?

A. No.

Q. Can we have a look at your email about this. INQ000484821. It's behind tab 37 in your bundle, please. Can we go, I think, to the -- down to the next page.

This is where you say: the approach is fine, it's the scoring system which is causing the anxiety at the moment.

Then if we can go up to the first page, please, and this is your deputy Chris Jones saying:

"Yes agreed, very helpful suggestion."

So this tool had been circulated to you, or to the Office of the Chief Medical Officer, and you've been asked for your input on this and you have given your input and they have accorded with your suggestion of removing the numbers.

A. Yes.

Q. So what did the Welsh Government do in relation to this tool? Was it circulated amongst -- what --

A. Yes, it was circulated by the Welsh -- excuse me, by the Welsh Intensive Care Society and the trauma network. So it was circulated to all the relevant clinicians.

Q. Do you know whether that tool was used within local health boards to make decisions about prioritising patients for critical care?

A. I suspect it was helpful to clinicians but I don't know that for sure. You'd have to ask them.

Q. Can we come on, please, to the topic of do not attempt cardiopulmonary resuscitation (DNACPR) notices.

I think there was, throughout and prior to the pandemic, an All-Wales DNACPR policy for medical professionals --

A. Yes.

Q. -- calling Sharing and Involving. I think the version in circulation at the beginning of the pandemic was version 3, published in 2017, and that was updated in 2020.

Did the Office of the Chief Medical Officer have any involvement in formulating that DNACPR policy for Wales?

A. Well, I didn't have any personal involvement. Now, Chris Jones may well have been involved and discussed it

with the clinicians who led on it, because it was a clinically-led document, and in as much as it became a Welsh policy, it would have been approved, you know, by -- ultimately by the minister I guess.

Q. Thank you.

Now, in relation to issues around DNACPR notices during the pandemic, on 17 April you, together with the Chief Nursing Officer of Wales, issued a joint letter to all the local health boards.

Can we get that up, please. It's INQ000300106.

This is behind tab 41 in your bundle if you want to look at the paper copy, Dr Atherton.

A. Thank you. Yes.

Q. If we can move down that page, please, on page 1. You've indicated that you'd been made aware:

"Recently, we have been made aware of concerns from the groups advocating for disabled and learning disability communities in Wales about how the Clinical Frailty Scale ... could be used inappropriately in making decisions on escalation of care and 'do not attempt cardiopulmonary resuscitation' ... for individuals being treated for Covid-19."

Just pausing there, under the All-Wales DNACPR policy, would it be appropriate to take the clinical frailty scale into account when imposing a DNACPR?

A. I'd have to read through the policy to see whether it's mentioned in there but I think it would be appropriate for it to be one of the considerations which clinicians would use to determine about whether an attempt at cardiopulmonary resuscitation should be made.

Q. Thank you.

If we can look at page 2 you identify that:

"There have also been concerns raised by the Older People's Commissioner ... about the care and treatment options that will be available to older ... people, some of who have felt pressurised into signing DNACPR forms."

You have gone on to say that you were not aware of any CPR decisions being made purely on the basis of an individual's age, disability, autism, mental illness or other condition but nevertheless you felt it important to write out to the system to provide some measure of reassurance; is that correct?

A. That is correct, yes.

Q. You go on to say age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes.

Was that your understanding at the time that it was necessary to have patient consent to a DNACPR order?

A. Yes.

Q. Thank you.

A. I need to clarify that. So if a patient has mental capacity, then it's clearly a duty on doctors to have that discussion with a patient before they make that decision. It becomes problematic where people don't have mental capacity, in which case the discretion would normally be had with the relatives or ...

Q. If I can take you back, not to have a discussion but to have consent.

A. Yes.

Q. Did you consider it was necessary to obtain a patient's consent to a DNACPR order or did you think that that was a clinical decision for a doctor that should be discussed but wasn't determined by --

A. I think there can be -- it would be very unusual to have a DNACPR order without the patient's consent but the patient can't always give consent, of course.

Q. Thank you.

You go on to say:

"It remains essential that decisions are made on an individual and consultative basis with people. It is unacceptable for advance care plans, with or without a DNACPR form completion to be applied to groups of people of any description. These decisions must continue to be made of an individual basis according to need and individual wishes."

What was it about advance care plans that was objectionable in your view?
A. It wasn't advance care plans which were objectionable. I think advance care plans are excellent if used appropriately and we have a whole process in Wales of developing advance care plans.
Q. Can I take you to the wording, please, of the letter that you sent out:
"It is unacceptable for advance care plans, with or without DNACPR form completion to be applied to groups of people of any description."
Do you think that the message there was potentially a little confusing, that there was something unacceptable about advance care planning?
A. No, I don't agree with that at all. I think it's clearly saying that advance care planning cannot be applied to groups of people; they should be applied to an individual not to a group of people. I think that's absolutely clear in the text.
Q. What did you understand by advance care planning?
A. Advanced care planning is the discussion that you have with an individual or, on occasions, with the relatives of an individual, or sometimes with both, about what their future wishes will be. So it may include discussion around DNACPR; it doesn't have to include

a discussion around that at all. It may include a discussion about their advance wishes, you know, if they become ill or if their condition was to deteriorate. So it covers a whole range of things. And there's a comprehensive suite of documents which is produced by -- we have in Wales an advance planning strategic group, again led by clinicians, that develop and update all of these documents and tools.
Q. Thank you.
In this letter that you've sent on 17 April, I think there's a link, I think further down the letter -- forgive me, it's on page 1, I think -- to the statement of the Covid-19 moral and ethical guidance in Wales, and you don't appear to have signposted in that letter to the existing All-Wales DNACPR policy. Do you consider that that was an oversight?
A. Well, I think that that would have been quite widely circulated not by Welsh Government as we just discussed but by the clinical network, and I think it was more targeted towards the leaders of the intensive care systems really. I'm sure medical -- excuse me, medical directors would have seen it.
Q. If we can scroll up, please, we can see who that letter was actually addressed to. And it was addressed to the Health Board chief executives, the medical directors,

directors of nursing, and directors of therapies and healthcare scientists. So this was going out to the local health boards. Do you think it would have been helpful for those recipients of the letter to have been signposted to the existing detailed DNACPR policy?
A. It may have been, it may have helped, yes.
Q. Thank you.
You wrote again to the system with the Chief Nursing Officer on 10 March 2021. This time you were writing following media reports, I think, of inappropriate DNACPR notices in England in relation to people with disabilities or learning disabilities specifically.
Were you aware at that point of any similar issues in Wales?
A. There had been a couple of instances where it had been brought to our attention that there may be problems with that issue. I think one was out in west Wales and there was a practice somewhere, I think in one of our health board areas, where it was reported that there had been inappropriate -- either group or issuing of DNACPR without proper consideration or discussion with the patients as we were just discussing.
So that's what triggered the second letter, as I recall. It was a reminder.

Now, none of those experiences, as far as I could see, were ever clinically -- I mean, obviously it was a very difficult time and people were anxious about decisions being made about themselves, about their loved ones, but I don't -- what we made very clear to the system -- again through medical directors, we discussed this at medical directors' meetings -- was that when a DNACPR process was felt not to have been followed, if a patient or a relative complaint about that, that it should be properly investigated by the health board, and as far as I'm aware that did happen.
Q. I think in fact you wrote out to the system for a third time in April 2022 and on that occasion there was reference made to a specific incident that had taken place in relation to a patient with a learning disability who had had a DNACPR notice issued solely on the basis of that learning disability.
I think, again, in the letters of March 2021 and April 2022 there was no link or reference to the All-Wales DNACPR policy for clinicians. Do you know why that wasn't linked in those letters or referred to in those letters?
A. No, I don't know. I do not know why that was.
Q. Having been made aware then of both media reports and some specific incidents in Wales in relation to

inappropriate DNACPR notices, did your office or any other Welsh Government body, to your knowledge, either investigate or commission an investigation into whether there had been a widespread issue with inappropriate DNACPRs in Wales?

A. I don't recall commissioning anything or Welsh Government commissioning anything but the implication that these were widespread was not something that certainly I felt or Jean White or Sue Tranka subsequently felt was an issue.

These were rare events which needed to be investigated by the health boards and our view was that even one event was wrong and it should be absolutely not the practice and that's why we consistently wrote out to the system.

Q. Can you tell us how you came to the conclusion that these were not indicative of a widespread practice in the absence of any review or investigation?

A. Well, it's really not the Welsh Government's responsibility or ability to monitor the number of DNACPRs or whether they're appropriate or not. That's really a job for the health boards. So when all this was coming up repeatedly we had discussions with medical directors who were responsible for overseeing within their health boards how the DNACPR policies were being

implemented.

Q. Did you ask the local health boards to undertake that sort of review?

A. I didn't, no, no.

Q. Did you ascertain whether the local health boards had policies that were in accordance with the all-Wales DNACPR policy?

A. Well, there was an expectation that they would have that. I mean, that was clear in the DNACPR policy that individual health boards should be having their own policies and monitoring their policies. It's the health boards to monitor the policies and implementation, not the Welsh Government.

Q. So those three letters to the system did not refer to the all-Wales DNACPR policy. Were any steps taken during or after the pandemic to ensure that clinicians in Wales were familiar with and fully understood the all-Wales DNACPR policy Sharing and Involving?

A. Well, the policy is updated every two years. I think it was updated again in 2022. Whenever it's updated it goes to medical directors. I've talked already about the advanced care planning policy and processes and the tools that are contained within there. So tools are widely available to staff and health boards include them in their staff training.

So I am reassured that the system does have that training, that -- and the monitoring function through the health boards, yes.

Q. Are you aware of the -- turning to advance care planning specifically rather than DNACPR notices, are you aware of the ReSPECT forms that are used in many regions of England and, indeed, in Scotland to record patient wishes and views in terms of advance care planning and are there any reasons why the ReSPECT form could not be adopted in Wales?

A. Can I just backtrack slightly just to correct something which I previously said. I think Healthcare Inspectorate Wales undertook an audit of DNACPR policies in Wales in 2024.

Q. In 2024?

A. I think it's very important we, kind of, look at that because HIW is the body which sits, if you like, above the health boards and monitors their compliance with some of the policies that came out. So there is a -- there is a piece of work around that.

Q. So as far as you are aware, there is an audit of policies but not an audit or review of individual DNACPR --

A. No, that would be done by there health boards. The audit of the policy and how it was being adhered to by

the health boards would be done by HIW, yes.

Q. But you're not aware whether the health boards did undertake any such review?

A. Well, I wouldn't know that but the HIW report may well refer to that because it should look at that.

Q. Thank you.

A. I'm sorry to go. Back to your question maybe.

LADY HALLETT: The question was: is there any reason why the policy of ReSPECT used in parts of England should be used in Wales as well?

A. As I say, we do have an advance care policy and we -- that's updated regularly. It's not owned by the Welsh Government, it's a network issue again. As I understand it, the clinical leads of that do look, whenever the policy is updated, at the ReSPECT process.

There are some concerns in Wales from some groups that it's perhaps not the -- it doesn't meet all of the needs in Wales. I think the principles of the ReSPECT process are incorporated within our advance care planning but the tool itself, elements are taken from it but I don't think there's a desire to -- wholescale just to adopt that policy. We have our own policies in Wales which we believe are robust, and actually, in some ways, more comprehensive, because it's not just a policy, it's a suite of tools which people can use.

LADY HALLETT: Thank you.
MS NIELD: Moving on now to your views of the lessons learned from the healthcare system response to the Covid pandemic, what do you consider to be the most important lesson that can be learned from the response of the clinical healthcare system in Wales? And do you have any recommendations building on that for future pandemics?
A. So I mean, I don't want to just reiterate some things I've already said, I'm sure you've heard this before.

The big lesson to me was that the system didn't have enough capacity to be able to respond in the way that we needed it to and in a way that's because -- we've tried to make our NHS, and it's true in Wales as in the rest of the UK, as efficient as possible, and in some ways efficiency is the enemy of preparedness, because we don't have the sufficient expanse in capacity.

So the biggest lesson for me is thinking about how we can expand capacity in intensive care, as we have been discussing. We did expand intensive care capacity, from 152 beds to more than 300, we more that doubled, but there weren't the staff trained to be able to move into those positions.

So thinking about how much spare capacity for all

sorts of things, we talk about intensive care, but for all sorts of things is really important going forwards.

The second thing is the flexibility of the workforce, the ability to move the workforce, who did a fantastic job, but to move them and to make sure they have multi-professional skills that can move between roles when needed. I mean, that's my first recommendation.

The second one really is more about the basic health of people in Wales. This is a big ask but the health of people in Wales is not as good as it needs to be. We didn't start from the right place and so when we talked about those inequalities, we talked about the differential impact on people, but if those inequalities were smaller, if the basic health of the population was better, we would have fared better than we subsequently did.

Yes, those I think are the main areas that I think -- I am sure our communications, you know, could have been better but that's an internal matter and we can think about that. Some of the connections, do you remember we talked about the connection on policy level between Welsh Government and -- the devolved nations, let's say, and the UK Government. Strengthening those would be really important as well. Those are the, kind

of, main things which come to my mind.
MS NIELD: Thank you very much, Dr Atherton. I have no more questions for you.
LADY HALLETT: Thank you, Ms Nield.

Mrs Weereratne.

She's that way.
A. I see her thank you.

Questions from MS WEERERATNE KC

MS WEERERATNE: Good afternoon, Dr Atherton.

I ask questions on behalf of the Welsh Covid Bereaved Families for Justice group, many of whose members lost loved ones through nosocomial infection, and I have a number of questions for you on their behalf today.

The first is this: today you were asked about the EMG report of 4 June 2020 which said that there was weak evidence of transmission, and you were asked about the application of the precautionary principle.

In fact, the EMG report states that: the evidence of aerosol is weak but there is significant uncertainty around the relative contribution of all transmission routes; the approach to risk should be based on the well established hierarchy controls.

So the Welsh bereaved are concerned that when asked about the precautionary principle, witnesses tend

to revert to masks and suggest that application of the principle would, as you suggested today, result in everyone wearing respiratory hoods. Do you think that when considering the precautionary principle the focus is in fact too much on such outcomes like masks than on the risks arising from the science?
A. Forgive me, it's a rather theoretical question. I'll try to answer it.

I do think at the stage we were at in the pandemic, even in June 2020, the risks, the modes of transmission were all becoming clearer. They weren't entirely clear. I think I've already mentioned the precautionary principle. I don't just apply it to masks, I don't think. I do apply it to the whole process of healthcare but it's only one tool in the box. It's not the only or the one that supersedes all others. I do think we have to balance evidence very carefully and that's why we created the scientific architecture, including the EMG that you mention, feeding into NERVTAG, feeding through into the IPC cell.

I do think that the precautionary principle can mislead us sometimes because it can be argued both ways. It can be argued as a reason to do things and as a reason not to do things.
Q. I think that reflects your earlier answer but may I ask

just this: what was the downside in your estimation of assuming that long-range aerosol transmission was taking place when the evidence for it was weak?

A. I don't think we did assume that it wasn't taking place. As I say, there's a continuum of droplets to small particles to tiny particles. I think that was understood really from quite early on. So I don't really think that that -- sorry, ask your question again please, can you?

Q. What was the downside -- you talked about the downsides of assuming that long-range transmission was taking place when the evidence was weak.

A. So there was an acceptance that particles of all sizes -- the empirical evidence was the closer you were to somebody, to somebody who was infected, the greater the risk. That came about very early and didn't really change. So there was a good reason to take the action that we -- that the IPC cell did take.

Q. Thank you.

I am going to ask you my next question. We also heard your evidence this morning that there was an anxiety around the levels of PPE stock that you were holding. At paragraph 174 of your witness statement you say that you do not recall any specific concerns on shortages of PPE or poorly fitting PPE that was notified

to you directly.

Now, on 4 June, Vaughan Gething told the Senedd Health, Social Care and Sport Committee that Wales came within days of supplies of some items rather than weeks. So in the light of all of that, do you agree that there were issues with the supply of PPE at the early stages of the pandemic in Wales?

A. So thank you. Very early in the pandemic there were real concerns, visceral concerns that we were going to run out of PPE. The stocks were running down very, very quickly. I think what I say in my statement is that, you know, I was never informed that we actually ran out of stocks. I believe that to be true. We never in Wales ran out of stocks. I think we came very close but we continued to keep the pipeline of stocks moving into health and into social care to keep those pipelines moving.

Now, what I can't say is that there weren't local distribution issues because obviously the local health boards had to receive stock and distribute them within their -- both the healthcare facilities, primary care and subsequently into social care as well, so there may well have been local distribution -- but we never ran out of PPE, yes.

Q. Thank you. I'm just going to remind you that it says

"do not recall any specific concerns on shortages", not running out, but I'm going to move on to my next question, which is on supply again.

Concerns are raised in an email trail -- I'm going to ask, please, if we could have INQ000383997, page 1, up on the screen, if I may.

It's an email trail dated 27 March, and it's the first page to the bottom of the first page that I want to ask you about, Dr Atherton.

It's between -- it's sent by clinicians from health boards in Wales and ultimately brought to your attention at the top of the page where it says:

"Hi Frank ..."

Do you see that?

A. Yes, I do. Do you have a tab number, please? I find it difficult to read these --

Q. It should be 57, I apologise.

A. Tab?

Q. 57.

A. Thank you.

Q. I'm looking at the screen because there are some redactions on the version there which were not in the version that I downloaded last week, but I see your name is there. So perhaps you can look at that copy.

So you were sent an email saying that there is

a situation in Swansea, contrary to a discussion about unified PPE approaches across Wales following Public Health England advice.

That's the top email. You see that.

It forwards to you the email below from Esther Youd, and that says she entirely agrees with the comments regarding the need to unify Royal College guidance with PHE guidance on infection control.

Do you see that? It's the second paragraph there, or the third paragraph that I'm interested in, where it says:

"[Frank] ..."

And that's correct, it says "Frank", doesn't it?

"... made it clear that it is important that we all follow the PHE guidance so that high levels of PPE are not used unnecessarily, risking the supply chain at a later date."

So my question is this: do you agree that decisions were being made as to what level of PPE should be used by healthcare workers to avoid running out of supplies rather than due to the risk presented to healthcare workers?

A. No, I don't agree with that.

So this email chain, you know, was sent to me actually by David Tuthill, who's a paediatrician working

in Wales, a very, very gifted paediatrician, and he was raising the issue of whether babies should be regarded as Covid --

Q. Sorry, Doctor Atherton, I am really going to stop because I have limited time, but I just wanted to focus you on to the comment that was made by you that you were concerned that it was necessary to follow guidance so that high levels of PPE are not used. The context is not necessarily necessary at this point.

A. Understood. Thank you for that. Yes, thank you.

So that's the reported account of my discussion that I had with the Academy of Medical Royal Colleges Wales. I met with the academy on a regular basis throughout the pandemic and all of the clinical leads, the college leads, would have been present at that meeting. So this is a reporting of what I'd said at that. And basically what I was saying at that meeting, from my recollection and from what I'm seeing in front of me, was that it was important that we follow the IPC guidelines.

I'm not saying that the primary reason is because of a stock level. I don't believe that I felt that at all. I mean, it may well have been something -- a concern, a subsidiary concern, but the main reason for following IPC guidance was because that was based on the

best evidence that we in Wales and we in the UK had through NERVTAG and the IPC cell.

So it wasn't a question of supply.

Q. But you accept that that is accurate in terms --

A. Well, I accept that's what he said, I accept that's his interpretation of what I said, but I would have had a 40-minute discussion with the academy and he may have taken one line from that.

Q. Thank you.

My next question is on asymptomatic testing. At the Senedd's Health, Social Care and Sport Committee on 18 March you said -- and that's 2020:

"I just need to stress that there's very little point in testing anybody who is not symptomatic. The test will only be positive if someone actually has symptoms."

So at this date it's correct to say, isn't it, that you did not believe there was any point in testing asymptomatic healthcare workers?

A. Date of that again, please?

Q. 18 March 2020.

A. So at that point in the pandemic, asymptomatic infection was starting to be recognised. Asymptomatic transmission was not regarded as a very significant mode of transmission. Now, that became -- that changed over

time but in early March, when we were still learning about the virus, that statement would have been true.

Q. Oh, thank you.

The next point then is that testing of asymptomatic healthcare workers in England started from 30 April 2020, and you further said to the BBC then that the Welsh Government was "still trying to reach a cross" --

MS NIELD: I do apologise for interrupting. I think it has been necessary to stop the live feed.

(Pause)

I think we can resume shortly.

(Pause)

LADY HALLETT: No, I'm not going to stop it. Somebody can alter that later if it has been mentioned in error. We can go back over it and amend it. We're short of time this afternoon, so no.

Please carry on.

MS WEERERATNE: All right. I am going to repeat that question. I'm sure that would help you, Dr Atherton.

My question was around testing of asymptomatic healthcare workers from 30 April 2020 and that you said to the BBC that the Welsh Government was:

"... still trying to reach across to England to understand the exact rationale for the changes that

they've made in various categories."

So the question is: why did you not recognise the value in asymptomatic testing at that time and at that date, 30 April 2020?

A. Thank you. Look, I have to confess I'm a little puzzled by the question because in March 2020 there was very little testing capacity available. So it certainly wasn't the case that England or anywhere was testing all healthcare workers who were asymptomatic. Asymptomatic testing came in much, much later, round about September/October/November 2020.

Q. Well, I can reliably inform you that on 30 April England started asymptomatic testing of healthcare workers?

A. Not of all healthcare workers.

Q. Well, that is my question to you.

A. They couldn't have, because there just wasn't enough capacity.

Q. So my question is focused on the value of asymptomatic testing at that time. Do you accept that or not?

A. Well, at that time, in April 2020, as in March, there wasn't an understanding that asymptomatic transmission was a main -- a significant feature of the pattern of transmission of the disease.

Q. Okay, thank you.

So I will move on to the next question, which is

that at a Senior Clinicians Group on 4 May it's minuted that approximately 5% of staff are asymptomatic carriers, with up to 9% in one hospital, CF 0.64% in the community from an ONS study. Then it records:

"Need to be really clear why we will not test all HCWs."

So again the question is, do you agree that by 4 May 2020 it was untenable to maintain a stance that there was no value in regularly testing healthcare workers regardless of symptoms?

A. I think by the time we reached May it was becoming increasingly clear. And this was -- as I recall, this was quite a complex paper which Aidan Fowler, the Deputy Chief Medical Officer in England, one of the DCMOs in England, brought to the Senior Clinicians Group. It was a very preliminary finding from the Vivaldi Study.

And it did concern me. I think it concerned all of us that that there was a relatively high prevalence of asymptomatic infection -- not asymptomatic transmission, you know, but asymptomatic infection -- among healthcare workers.

The comments I think that I made at that time was: well, if that's the case then we will need to move towards testing asymptomatic healthcare workers at some point.

Q. Yes, so the policy was in December 2020, and I'm asking you: do you know and do you accept that it wasn't actually rolled out until mid-March and July 2021? Just answer that if --

A. If you let me finish my answer, I know that the supplies of the lateral flow devices that came into Wales were distributed in December, fairly quickly after the policy was agreed through our TTP programme. They went out to all the health boards. I think there was a variance in the speed with which the health boards were able to implement the testing. So in terms of full roll-out, I suspect you're right, that some health boards didn't quite get there as quickly as we would have expected.

I think there are two other things you need to think about when you look at that. One is what else health boards were doing. And if you remember, this was exactly the time, my Lady, that vaccines were being brought in, and so there was a huge impetus on getting vaccines into people.

And the other thing I would also flag is that although there was a delay -- I think health boards could have been quicker, I will accept that -- I don't think the situation was much different in England, which is obviously a much bigger system anyway.

So I think those comparisons are perhaps not

At that time, on 4 May, again, there was not sufficient capacity of PCR testing --

Q. Thank you --

A. -- within the system to be able to undertake that.

Q. I think you've answered my question --

A. Subsequently, it's when lateral flow devices became available, widely available, that that become a feasible option. But it just shows -- I think that line just shows that we were thinking in those terms about how we could bring in testing for asymptomatic healthcare workers.

Q. Thank you.

I want to move to another topic, which is about introduction of routine testing.

Now, you have already been asked about the delays by the Welsh Government in announcing routine testing of healthcare workers in December 2020. I want to ask you about the incremental testing of healthcare workers which was due to be rolled out after that time, with full roll-out due to be January 2021.

Do you agree that the regime was not in fact rolled out until mid-March 2021, and often as late as July 2021 in some cases?

A. I think it was rolled out earlier than that as a national policy. Again, my colleagues --

entirely ...

Q. I am grateful. I'm moving on to another question.

In the expert report by Dr Shin, Professor Gould and Dr Warne, they say that hospital-onset cases during the first wave represented 5.3% of all laboratory-confirmed Covid-19 cases in England, 6.4% of cases in Scotland, and 10.5% of all laboratory-confirmed cases in Wales.

The question is why were the rates of hospital-acquired Covid-19 as a percentage of all cases so much higher in Wales?

A. If you read down that report you'll see that the professors also point out that not too much should be read into that because of the differences in counting, the differences in testing, the differences in hospital admissions. So they put enormous caveats around that data. So it's not data that I recognise.

The reality is that there were high rates, there were high rates in all the countries. I don't accept the -- just on the face of it, the differences in the statistics.

Q. Thank you.

I just wanted to ask you about the Covid pathway. There's a letter that we have, dated 9 April 2020, to all CEOs, the chief operating officer, and medical

directors of Welsh Health Boards and trusts in which you discuss the all-Wales hospital Covid-19 pathway, but it appears that a copy of this document no longer exists. So the question is, can you assist the Inquiry with why that is and why there's no copy retained in order to ensure accountability and compliance with that pathway?

A. Yes, I can. So the pathway was a very innovative piece of work done by one of our esteemed respiratory consultants, who I won't name, who was a consultant in west Wales, and he led the Respiratory Health Implementation Group, and was very effective, I think, early in the pandemic in assembling the evidence on what works and putting that into a toolkit which was available, including the pathway that you rightly describe.

That pathway was then distributed through a private company and the reason it's not available now I think is because it was in the domain of the private company rather than owned by Welsh Government.

LADY HALLETT: I think we're going to have to leave it there.

MS WEERERATNE: And that was my final question.

LADY HALLETT: Okay, thank you very much. Very grateful. Sorry about the interruption.

Right, Ms Hannett.

Questions from MS HANNETT KC

MS HANNETT: Dr Atherton, I appear on behalf of the Long Covid groups.

My Lady, in light of the evidence that was given this mornings we do not need to ask all the questions that we have been given permission for, so I anticipate I'll be a little less than the time that has been allocated.

Dr Atherton, I have questions first about your role in advising on the Long Covid. You gave evidence this morning that you were not involved in advice on the identification or characterisation of Long Covid, and you agreed that Dr Chris Jones was a member of the Welsh Long Covid subgroup. You stated that you couldn't recall being provided with a briefing by Dr Jones on the matters discussed at that subgroup.

Did, you ever ask Dr Jones to provide you with the briefing?

A. I don't remember asking him. As I think I said earlier, I think most of my information flowed through probably from Chris or from that group rather than Chris, through into the Technical Advisory Cell, and to me in that direction.

Q. And did you personally ever provide any advice to the Welsh Government on the identification or

characterisation of Long Covid?

A. I don't believe I did. I'm not an expert in that field.

Q. You describe your role as medical director of the NHS at paragraph 32 of your statement as a co-ordination role, through the sharing of common issues and best practice amongst medical directors.

You say at paragraph 92 that your office would meet with NHS Wales medical directors, directors of public health, to ensure learning and consistency across the health and social care sector.

Did you ever use those meetings to discuss Long Covid?

A. I honestly don't know. We'd have to trawl back through the minutes of those meetings. I would be surprised if we hadn't or if it hadn't come up in some form, whether as a specific item or any other business or as something which was raised by members. I think it would have been discussed but I can't tell you whether it was.

Q. Does that mean you can't recall, yourself personally, providing advice on Long Covid to that meeting?

A. Yes.

Q. Similarly, many Long Covid patients reported that they weren't believed when they sought care and support from clinicians or that clinicians didn't know how to support them. Did you take any specific steps in your role as

medical director to ensure there was awareness of diagnosis and care for Long Covid sufferers?

A. Me personally, no, but I think that the communication -- it was understandable in the early days of the pandemic that primary care particularly, but doctors generally, wouldn't have known really how to handle these kinds of questions. I think as the evidence became assembled that there was more communication I believe from the group, but not from me personally, no.

Q. Not from you.

Can I just now ask you about Long Covid services. NICE guidance published in December 2020 recommended specific Long Covid clinics. Similarly, the Welsh Technical Advisory Group, on Long Covid, at February 2021 recommended integrated multidisciplinary care pathways for Long Covid.

Wales has not developed specific Long Covid clinics. Did you provide any advice to the Welsh Government or to the health boards, after either the NICE guidance guidelines or the Welsh Technical Advisory Group on what services should be provided for Long Covid in Wales?

A. Me personally, no, but I am aware, of course, that the group we just discussed has been providing that advice and that systems have been set up to support people with

Long Covid in Wales.

We've taken a different approach, it is true. We have a much more community-based approach. One of the main reasons for that is that we are trying to shift many of our services into the community.

There are specialists who are active in the field of Long Covid. I think we're still learning a huge amount about Long Covid. The vast majority of the people -- of people with Long Covid I think should be treated and treatable within the community. Those few who cannot should have access to specialist care. We need to make sure that happens in Wales. It does happen to a degree, probably need to expand it more. But that's the approach we've taken in Wales.

Q. Thank you, Dr Atherton.

Have you personally taken any steps at all in relation to Long Covid? You personally?

A. No.

Q. Can I ask if that's because Long Covid wasn't a priority for the Office of the Chief Medical Officer?

A. Well, I it wasn't early on. And latterly that function has been discharged through my deputy, who has much more of an interest and much more of an expertise in that area.

Q. Can I just ask you about that, because your evidence

doesn't set out any steps taken by Dr Jones, and Dr Jones' own witness statement doesn't give any account what steps he has taken in respect of Long Covid. So the Inquiry isn't actually in a position to understand what steps the Office of the Chief Medical Officer has taken in respect of Long Covid in Wales.

A. So the group that's looking at that, I think we established that Chris is probably a member, I don't think we established that he certainly is but I think we established he's probably a member of it, but there's a whole group working on that important issue. And they will -- they have produced recommendations, they've led to the development of services, the Adferiad service in Wales, which is our community-based multidisciplinary service.

So service development is going on. Whether it needs the Chief Medical Officer involved in that, when I'm not a specialist in that area, is a moot point. But there are clinicians closely involved in it with strong interest and strong professional background.

I think it's also important to flag that we need to support people with Long Covid, absolutely we do, but there are a range of other people who, you know, suffer from various post-viral syndromes and we need to make sure that we don't forget about those as well. And

I think that's been at the forefront of thinking as we've developed the Adferiad service in Wales.

Q. Can I just ask you this, Dr Atherton, finally. Given that the Welsh Government has estimated there are some 96,000 people with Long Covid, and given that that can be a condition which is both long-term and disabling, do you agree that that should be a public health priority in Wales?

A. I think it should be a priority and has to be looked at in terms of all the other difficult issues which health boards are responsible for. At the end of the day it's the responsibility of health boards to develop those services, to understand the needs of their population, and to make sure that the services they provide meet those needs.

MS HANNETT: Thank you.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Hannett.

Ms Waddoup. Over there.

Questions from MS WADDOUP

LADY HALLETT: I don't think you are switched on.

MS WADDOUP: Dr Atherton, I ask questions on behalf of Clinically Vulnerable Families, and I would like to ask you first, please, about communication.

The CMO's technical report acknowledges the

importance of communication in relation to clinical vulnerability and, in particular, the need for communications to be clear about who was vulnerable, what was being asked of them in the guidance and why, as well as the reasons for changes in that guidance.

Do you think that communications in Wales to the clinically vulnerable and clinically extremely vulnerable in relation to those issues were sufficiently clear, prompt and regular?

A. I certainly hope they were. We tried very hard to make -- to fill all those criteria that you just rightly described, because communication with this group was really important. As we discussed earlier, we were asking them to do something really very, very difficult.

In Wales we had a team working on this. We didn't just produce formulaic letters, or we tried not to. We tried to personalise it. We tried to make Easy Read versions available wherever possible. So, for example, for the -- we talked about people with Down's syndrome. We produced an Easy Read, which I think was a really good model of good communication. And of course we tried very hard to do everything -- we did everything in Welsh as well as English, so we had that additional thing that we absolutely needed to do.

Could we have done better? Of course. You know,

we could do better. We always need to learn how to do better. Our communication needs to be better. It was not easy.

As I think I've said, I've spoken to some people in that group, I'm sure you've spoken to many more, who were kind of grateful for the way we communicated. I'm sure there are plenty who felt that communication let them down and should have been better, and we need to learn from that.

Q. Thank you. That actually leads me to my next question, which is about understanding the impact of the shielding programme.

We know that in Northern Ireland a survey of those shielding was carried out which identified, amongst other things, a number of adverse social and psychological impacts associated with shielding, and we've heard in evidence from your colleague, Professor McBride, that the results of that survey, published in July 2020, were used to inform his advice after that, for example in relation to the pausing of shielding, formulation of communications, et cetera.

We understand that in Wales there weren't any specific surveys of those shielding about the impacts on them whilst the programme was in place, and my question is: should there have been?

A. Well, I didn't know actually about the Northern Ireland approach until I heard it, as you did, from Professor Sir Michael McBride, and I think it was an excellent piece of work that they did there.

I don't remember it being discussed at the time. I think -- I agree with you it would have been useful had we had the time and the resource to be able to do that. We would have learnt much more. So the answer to your question is yes.

Q. Thank you. Then, finally, I have a question relating to measures taken to protect clinically extremely vulnerable and clinically vulnerable patients while they were accessing healthcare.

In your evidence this morning you described the very close consideration being given to providing surgical masks to clinically extremely vulnerable patients when they were coming to hospital in order to support them.

Was consideration given to providing clinically extremely vulnerable and clinically vulnerable patients with higher-grade, better-fitting masks like FFP2 or FFP3 masks, and if not, why not?

A. No. Well, I'm not saying it wasn't considered, I'm saying it wasn't a policy. I think that the view is and was that surgical masks provided good protection in

largely non-clinical spaces or the clinical spaces that those clinically extremely vulnerable or clinically vulnerable people would have been moving into. That was the basic provision, of course, for healthcare workers as well at the time.

I think that had we suggested -- had there been a suggestion -- I don't remember anybody ever suggesting FFP3 masks. I think that would have been extraordinarily difficult given the issues around fitting and fit testing et cetera. FFP2 masks were not widely used in Wales or in the UK generally, interestingly, which is a complete contradistinction from the rest of the Europe, but they weren't a factor in thinking.

So it was felt that the best protection for those groups was through the provision of surgical face masks.

MS WADDOUP: Thank you, Dr Atherton.

My Lady, those are all my questions.

LADY HALLETT: Thank you very much indeed.

Mr Thomas.

Mr Thomas is sitting behind you, so please could you make sure that when you answer his questions you turn back, but by all means look at Mr Thomas whilst he is asking the question.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Thank you, my Lady.

My Lady, just so you don't become confused, I'm taking my questions 3 and 4 out of order. I'm doing them first.

LADY HALLETT: Thank you.

PROFESSOR THOMAS: Dr Atherton, I'm representing the Federation of Ethnic Minority Healthcare Organisations (FEMHO), who advocate on behalf of healthcare workers from the black, Asian and minority ethnic communities who were disproportionately affected by the pandemic, okay.

When did you first become aware that there was an issue of disproportionate infection and death rates amongst black, Asian and minority ethnic healthcare workers and patients?

A. Thank you, Mr Thomas. I can't pin a date on that but I think, you know, the early data coming out of the first few hundred studies which were commissioned in the UK, that's looking at the demographics and the outcomes and the treatments provided to the first hundreds of patients that come through the system with Covid, I think that started quite early on to shine a light on the fact that there was a disparity, which you describe, in terms of, first of all, infection and,

subsequently, the mortality issue.

So if you were to ask me -- if you tried to pin me down on dates, I would say April into May probably, but that's when we were starting to see significant numbers of patients.

Q. Let me just ask you just a very quick follow-up on that. So when you became aware April into May, what immediate steps were taken to mitigate this risk?

A. So at that point it was still about gathering information. It wasn't entirely clear what was happening. The process in Wales was to make sure that we tried to understand it better. It was really about understanding.

And really quite on -- early on, of course, our First Minister and the minister for health took a very strong and active interest in this and established the council of Inquiry which Judge Ray Singh chaired. So there was a specific group set up to look at the broad issue of how people from the communities you describe were faring and then a specific subgroup which was to look at the risks that healthcare workers specifically were facing and to come up with recommendations about how they could be better protected.

Q. Right, so the answer to my question, if I've just followed your answer, apart from looking at the data,

there were no immediate steps taken?

A. There were two steps taken: the ones I just described, which was to set up a group to look at the issue broadly in terms of the impact of Covid, and specifically around healthcare and the impact on healthcare workers.

So I think those are fairly specific.

PROFESSOR THOMAS: My Lady, question 4 has just been answered so I'm going to come back to questions 1 and 2.

LADY HALLETT: Thank you.

PROFESSOR THOMAS: In your statement at paragraph 267 you mention that Covid-19 exacerbated existing inequalities, and in paragraph 273 you discuss how reducing these inequalities became a central ambition to shift towards prevention.

My question: could you please identify what, if anything, has been done to reduce these inequalities as you suggested.

A. Do you mean during the pandemic or subsequently?

Q. Well, let's start with the pandemic and then let's turn to subsequently.

A. During the pandemic I think I've highlighted a few actually, earlier in my statement. I can go over them again if you like. But it was specific to different groups who were being disproportionately affected. I mentioned taxi drivers, I mentioned the risk

assessment tool for healthcare workers, I think I mentioned the migrant workers particularly from Eastern European countries who were working in quite difficult circumstances in some of our food processing plants. So there was some very specific things during Covid.

If you want to ask about how we're addressing inequalities more widely in Wales, this predates the pandemic but it's ongoing work. There's quite a lot that we're trying to do. We recognise that focusing on the early years and getting the early years right is really important. We've had a process of looking at adverse child events in Wales which has led to a better understanding of how we can support children and young people: support for free school meals, support for people coming out of the care system, because they often get left behind and when they emerge from the care system really struggle and so additional financial support for them. There are a number of things like that.

And then in broad terms -- and I realise this is kind of broad policy -- we work very closely with the World Health Organization to try to better understand our inequalities. We have a process called the WHESRi, it's a horrible acronym, it's about looking at equity,

it's a tool that we have developed jointly with the World Health Organization to try to understand our situation much better.

Q. Thank you.

Second question. In the report titled "[Coronavirus] and [the] Health Inequalities", at paragraphs 4 and 19 structural inequalities and additional effects of racism are identified as additional contributors to worsen Covid-19 outcomes. Question: was anything done to address these findings and was there any monitoring that was carried out?

A. So this was a real eye-opener, I think for all of us, and it came out of Judge Ray Singh's work, as I described, the kind of broader context of Covid rather than the specificity around the healthcare workers.

Yes, I mean I think that has fed into our whole process of thinking about race and race equity in Wales. We have a very elaborate race equity scheme. It's never perfect. We need to do further work on that. All of our departments in Welsh Government and across the NHS are focused on race equity issues. There's far, far more than we need to do, but in process terms, that's where we are, I think, yes.

Q. Were policies or actions implemented to address the disparities identified and to minimise preventible harm?

And if so, in your view, were these actions timely and effective?
A. In terms of the policy and practices, I think the thing that I'm most impressed by was the work that our colleagues in BAPIO, who I mentioned earlier, did undertake as part of that broader race equity work. They looked very carefully at the risks the healthcare workers were facing and they developed a risk measurement tool which was disseminated across the health boards, was used very widely in the health boards, and actually was then picked up across the other four nations of the UK. So it's the one thing I would, kind of, point to. I'm sure there are others. But there were practical implications which were coming out of those --
Q. I've got one more question, but just a cheeky little follow-up to the answer you have just given. You say that's one thing that you feel has been successful. How was the success measured?
A. By its uptake across the healthcare system in Wales and beyond.
Q. Okay.
Final question: with the benefit of your first-hand experience and engagement with healthcare workers, what do you think can and ought to be done to

reduce inequalities for ethnic minority healthcare workers to ensure that they don't suffer such disparate impact in the event of a future pandemic?
A. Well, I would probably broaden that beyond healthcare workers, but certainly within healthcare workers there are questions about parity of esteem, about promotion, about access to training, to learning opportunities. All of these are things which we're determined to get better in Wales at both monitoring and influencing.
Q. Would you also agree allowing them to have a seat at the table where decision are being made?
A. I think that's what I mean when I talk about promotion and, you know, getting more people into senior positions. Many of our -- if I think about the medical profession, many of our doctors in Wales, Mr Thomas, many of them are working in SAS positions -- that's subconsultant posts, my Lady -- and so their terms and conditions are not as good as consultants, and I think there's more that we can do, and we are doing actually, to try to ease the pathway for them into consultant posts. That's, kind of, one example.
The other bit of your question, broader, is more societal, is we do need to look at access to resources when we have something like a pandemic. People's access to statutory sick pay was limited sometimes according to

their socio-economic status and their race, their origins, and I think more consideration needs to be given to how we support people in those groups to do things like self-isolating, which was much more difficult for people in those groups.
PROFESSOR THOMAS: Thank you, Dr Atherton.
Thank you, my Lady.
LADY HALLETT: Thank you, Mr Thomas.
Mr Simblet.
Again, behind you to your right, Dr Atherton.

Questions from MR SIMBLET KC

MR SIMBLET: Good afternoon, Dr Atherton. I'm asking questions on behalf of the Covid-19 Airborne Transmission Alliance (CATA). You have supplied two detailed statements and given evidence in the course of the day. What's not in those statements is what you thought about the classification and declassification of Covid-19 as an airborne, high consequence infectious disease, and I want to ask you about that, please.
In January 2020 Covid-19 had been designated an airborne HCID, and you understood the rationale for that, did you?
A. Yes, I did.
Q. And what I want to move to is, that designation having been made, did you support actively the declassification

decision in March 2020?
A. Yes. I'll expand.
Q. Please do.
A. So it was inevitable that with a new disease like Covid-19, not knowing anything or very much at all -- yes, nothing, about the pandemic in January 2020, when it first became likely that we would start to see it in the UK, any new disease like that would be treated as an HCID, a high consequence infectious disease, and the reason for that, of course, is that we don't know enough about it, we don't know how infectious it is, we don't know how it would affect healthcare workers. We had had experience with MERS-CoV, not in the UK but in other parts of the world, where healthcare workers had been very severely and adversely affected.
So it was right to treat it as an HCID in the first instance. Once we started to see cases in the UK, that, first of all, no longer became tenable and, secondly, no longer became desirable.
It wasn't tenable because the HCID units only have a certain amount of capacity, and it wasn't necessary because we were learning more about how we could treat that, and it could be treated as a routine infection -- I shouldn't say "routine" but as a normal, perhaps, infectious disease as we would treat any other

respiratory disease.
Q. Thank you. Of course it was also an airborne HCID, and that moves me to my next question. Were there any discussions about the declassification decision being connected to problems with the supply or, as you said earlier, distribution or suitability of PPE or RPE?
A. No. The decision to move from being an HCID to not being an HCID any more had nothing to do with the availability of any particular form of PPE, no.
MR SIMBLET: Thank you very much for your answers.
Thank you.
LADY HALLETT: Thank you, Mr Simblet.
Ms Jones, Jessica Jones, get the right one.

Questions from MS JONES

MS JONES: Thank you, my Lady.
Dr Atherton, I ask questions on behalf of Care Rights UK, John's Campaign and The Patients Association, all of whom represent people drawing on health and social care and their loved ones.
In terms of what was known and when, your evidence in your witness statements is that from the earlier stage of the pandemic it was known that age was a significant risk factor for severe illness and fatality from Covid-19, and that this was known from at least the beginning of March 2020. Is that correct?

A. Yes, I would agree with that, yes.
Q. And at the same time, also in February and March 2020, the understanding in respect of routes of transmission was that the extent of asymptomatic and pre-symptomatic transmission was not yet known but that they could not be ruled out, correct?
A. Yes.
Q. In this context, do you agree that the decision then to discharge patients from hospital without testing them increased transmission and mortality from Covid-19?
A. I fail to see the connection between the two previous statements, but to your question about whether in March/April discharge policies should have included testing on discharge, no, there was no testing, there was very, very little testing. It would have been practically impossible to achieve that.
So, yes -- I mean, at that point in the pandemic, you know, we were just starting to learn about the virus. We were starting to develop testing. The result is the PCR testing, which then came onstream first of all in the UK, and then we did develop testing relatively quickly in Wales, but getting to the volume that would have been required would have -- that was much, much later.
Q. Dr Atherton, perhaps I can ask this which might help

with the connection: where you know that there is a vulnerable group, namely older people, and where you cannot rule out that there is asymptomatic and pre-symptomatic transmission, do you agree that a precautionary approach should have been taken in light of that evidence so that, using the terminology that you used earlier, in the balance of benefits and harms, the risk of harm caused by the decision to discharge without testing outweighed any benefit?
A. Well, leaving aside the supply issue and the fact that it wouldn't have been feasible -- I mean, there was a lot of thinking going on really in the early days of the pandemic. It was apparent that people in care homes were suffering, we started to see outbreaks, of course, in care homes, and the systems were put in place to try to limit that: the PPE was provided to care staff, discussions about spacing, about isolating people when they came back from hospitals. But it was much later that testing capacity became available and it became an option to start to test people being discharged from hospital.
So the precautionary principle really wasn't an issue there. The precautionary principle doesn't help you in terms of applying the whole suite of IPC arrangements which, if I'm honest -- you know, we talk

about care homes, I know there's going to be a future module looking at care homes -- we do need to be better at IPC arrangements and training and provision within care homes. That's where our focus should be. And testing is probably one small part of that.
MS JONES: Thank you.
LADY HALLETT: Thank you very much.
Mr Pezzani. You are over there.

Questions from MR PEZZANI

LADY HALLETT: I'm not sure we're getting you.
MR PEZZANI: Dr Atherton, I ask questions on behalf of Mind, the mental health charity. The first question is this: at paragraph 269 of your first witness statement you explain how in July 2020 you advised the First Minister that you remained concerned that the restrictions which were in place were leading to significant negative impacts on mental health and well-being, which were particularly acute for the young.
My first question is whether you can help with identifying the information upon which you based that assessment and which gave rise to your concerns?
A. No, I can't really point to any specific document or technical report or anything. It was really just recognising the difficulties that everybody in society, I suppose there was newspaper reports, all sorts of

things.

So we were hearing from the public in the same way as everybody was. These were not easy times for anybody. But there's no specific source of information I can point to.

Q. No. Can I seek to assist you by perhaps reminding you of a Mind Cymru report from the month before that, June 2020. It was a survey that found that over a third of young people in Wales had been unable to access the support that they sought during lockdown and over half of them said that that difficulty in getting mental health support had made their mental health worse.

Would that -- was that something that maybe had figured into your assessment of the state of children and young people's mental health?

A. I don't remember seeing the report. Of course, as I described earlier, you know, May/June, the river of information was flowing and it may be something that wasn't brought to my attention or I missed. But what I would say is I absolutely recognise the issue that you're describing because by that time, of course, we had suspended all non-essential, let's say, non-essential services within the health boards and mental health suffered -- mental health services suffered that same setback as people were redeployed to

the front line to try to keep people alive.

So absolutely there was a downside and a consequence to all of that, and it wasn't just young people but young people, as I think I said in the report -- so I'm grateful to you for bringing it to my attention because it does, as you rightly say, help me to understand the impact and we were aware of it but I don't remember the specific report.

Q. Thank you, Dr Atherton.

My second question is this. Are you able to assist on what immediate steps were taken to address this particularly acute negative impact on the mental health of the young in Wales?

A. I can't. I can't tell you the specific steps during the pandemic. As we started to emerge from the pandemic we gradually restarted all of our services and -- including mental health services and it was important that we did that. Of course, for all the services, physical, mental, there is a backlog of care which we need to deal with, and I am grateful to Mind not just for the tools that you -- that the organisation you represent has been putting into the public domain to try to help to deal with some of that through self-care, through community care, but there's so much more we need to do. So there's a backlog as we come out of the pandemic,

I absolutely recognise that.

Q. Thank you, Dr Atherton.

Just one more short topic which has already been addressed somewhat by Mr Thomas and that is inequalities.

My specific question to you is on the potential for compound inequalities. We've already seen your concerns about the impact of lockdown on young people in Wales in relation to their mental health. My question is whether children and young people's vulnerabilities to the harms from lockdown, which is a phrase used in a paper you presented in June 2020 for the Executive Director Team, whether that vulnerability to harms from lockdown was compounded by extant inequalities. So, for example, the risk to mental health may have been particularly acute for a child from a racialised community who is living in poverty.

A. I absolutely agree with everything you're saying, that there is almost a ladder of inequalities, different steps. So if you're from a black -- minority -- or a minority ethnic -- ethnic minority group and you are poor and you're coming from a socio-economic deprivation, in a poorer part of Wales, then your risk of both physical and mental well-being being damaged is much, much greater.

This is why we try, as I have tried to describe, to address this through our approaches to inequalities, but there's no doubt that you're right. There are layers of deprivation -- sorry, layers of inequality which affect people's mental health. I recognise that absolutely.

Q. I am grateful.

Just one last question. In relation to that, were there any immediate steps that were taken or in hindsight were possible to take to mitigate that inequality? For example, in relation to the issue of digital exclusion just at the time that many mental health services for children and young people were moving to remote delivery?

A. I think if we look at what happen through the education system there was a recognition that as education moved to online learning that people would be excluded. I can't remember the details but I think there was more provision of information technology support to people who didn't have access to it. It was acutely in our minds, really.

And even the -- the support I was, you know, applauding your organisation, the organisation you represent, for providing CBT and online support for mental health, I recognise that that's not equitably

provided if people are digitally excluded. It's absolutely something we need to consider as we try to improve our approaches to equity.

Thank you.

LADY HALLETT: Thank you very much.

Right, Dr Atherton, I think that completes the questions we have for you. I hope it hasn't been too long a day for you.

A. Thank you, my Lady.

LADY HALLETT: I am going to say the same as I have said to your colleagues. I appreciate the burden we place upon you and your office when the Inquiry asks you to contribute to the Inquiry by providing written material or by giving evidence. I will tell the teams to please not impose upon you again unless we absolutely have to. So if you do get more requests, then I am afraid it will be because they consider it inevitable. So thank you very much for your help to date.

A. Thank you, my Lady.

LADY HALLETT: I shall return at 3.40.

(3.28 pm)

(A short break)

(3.41 pm)

LADY HALLETT: Mr Mills.

MR MILLS: My Lady, the next piece of evidence comes from

our first spotlight hospital. For availability reasons we move from day of Welsh evidence to Northern Ireland. With that, may I please call, via the video link, Dr Catherine McDonnell, who will affirm.

DR CATHERINE McDONNELL (affirmed)

LADY HALLETT: Dr McDonnell, I'm sorry if we've kept you waiting. I am afraid we overran a bit this afternoon. Thank you.

Questions from COUNSEL TO THE INQUIRY for MODULE 3

MR MILLS: Your full name, please.

A. Dr Catherine McDonnell, former medical director of the Western Health and Social Care Trust of which Altnagelvin Hospital is a part.

Q. Just to give the date of your tenure, Dr McDonnell, that was between 1 March 2020, I think, and 23 June 2022; is that right?

A. It was indeed.

Q. Your witness statement, for the transcript, is reference INQ000477593.

Let us begin, please, with the background to Altnagelvin Hospital. Can you tell us, please, where the hospital is located and describe the demographics of the population it serves?

A. Altnagelvin Area Hospital is located in Derry/Londonderry, which is in the northwest corner of

Northern Ireland and abuts the border with the Republic of Ireland. The hospital serves a population of about 180,000 which is a mixed rural and urban population.

The demographics, it's got a very small ethnic minority community of about 2% but it has high levels of social deprivation with recent statistics telling us that a male in the area will live six years less than the average in Northern Ireland, that 22% of people live in poverty, as compared to 16% across Northern Ireland, and that it's got the highest level of non-elective inpatient admissions which is in keeping with what you would expect in terms of high levels of demand on health and social care services.

Q. Did the hospital's position close to the border present unique challenges during the pandemic?

A. I do believe it did. I suppose I should have mentioned that we do provide some cross-border services, in particular cancer services and emergency cardiac services, such as PCI, percutaneous, and interventions.

So -- and a large number of our staff live across the border so we have a footfall that crosses daily and at times during the pandemic that border was closed.

So the trust was required to provide paperwork to staff to identify themselves as essential travellers and some of our patients who were coming across the border

to look for services.

I suppose I'd also say because we are two different jurisdictions the guidance on restrictions often varied, and that in particular in the first surge, was extremely confusing for staff because there was so much rapid change and they were hearing some conflicting messages.

I also believe that we were particularly at some times not quite in step with the rest of the region in terms of our surges and our spikes and that might have been to do with some of the differences in terms of lockdowns. So if we unlocked early we got a footfall of residents from across the border to enjoy our restaurants and pubs and I think that might have contributed to some of our particular peaks.

Q. Can we move please now to staffing capacity. At paragraph 10 of your statement you say this:

"Altnagelvin had staffing shortfalls prior to the pandemic, particularly nurses and doctors, creating a high dependency on agency and locum staff."

Again, just thinking please about the location, did that have an impact on the hospital's ability to fill those shortfalls?

A. Absolutely. I understand that the Inquiry has already heard about the challenges in terms of the region and

workforce difficulties and as is quite common place that when there are shortfalls in a region it's most extremely felt in the peripheries. So we would have been a peripheral hospital to start with and that meant that we had had a long-standing strategy around trying to recruit and particularly with an international work stream and that had to slow up through the pandemic because of all the different -- the difficulties with travel restrictions with PLAB exams, et cetera, and that was for both medicine -- for doctors and for nurses.

It also means that when there are temporary funding for positions you are very rarely going to get people moving to a peripheral area, moving to a temporary post. So some of the Covid funding was temporary and it was very hard for us, for example, to really -- to bring additional staff into our infection prevention control team, into our outpatient health team, all sorts of challenges such as that. And I should add that in the Republic of Ireland, the terms and conditions for doctors are much, much better than they are within the region so that's also a long-standing and chronic difficulty.

Q. With all of that in mind, were you able to effectively recruit at all during the pandemic?

A. We used the regional workforce appeal and through that

appeal we got about 500 additional staff. Those staff were less likely to be on the acute front line but they certainly were very helpful in supporting us in delivering additional services that Covid required that we set up, such as vaccination clinics such as testing centres. So we definitely got some benefits from the regional workforce appeal but it was much more difficult to get highly skilled and professional staff such as nurses and doctors.

Q. Next, please, bed capacity. At the start of 2020 can you help us, please, with the ICU bed capacity at the hospital.

A. The ICU bed capacity was ten, ten beds in total which was -- and curiously, 7.5 level 3, and three level 2. As all organisations, we had surge planning in terms of determining how we were going to increase that capacity and the expectation of a high level of demand that required us looking at the footprint, looking at getting additional equipment, looking at getting additional staff and really setting up systems to look at how best to use that capacity should we be under excess demand. I can give some more detail, if you would like, as to what we did.

Q. Yes, please. I think it's right, is it not, that the plan was to increase this figure to 24 beds. Can you

help us with how this was achieved?

A. We were highly ambitious and we had not truly worked out that the actual bed constraint was not going to be the number of beds, it was going to be the number of staff that could staff a bed. So I don't think we actually moved beyond 14 to 16.

But we did have some innovative ways of trying to take pressure off our ICU in terms of developing high dependency beds within our respiratory units. We expanded the ICU to some extent by expanding and elevating what could be achieved in a respiratory ward by anaesthetists working into that respiratory ward, and the ICU itself was expanded by moving into recovery areas, theatre recovery areas, and additional spaces being set up by bringing theatre staff and training them up as ICU nurses, and additional anaesthetists joining the ICU team by the -- to technicians securing additional ventilators and all the additional equipment that was required to provide patient care within those beds.

So we gathered all of what is needed, not just beds, in terms of really providing that additional ICU service and had it well supported in terms of a very collaborative piece of work carried between respiratory consultants and anaesthetists.

Q. Dr McDonnell, that's very clear, thank you. Can I ask you try, if possible, to slow down your answers. We have a stenographer trying to keep up.

Can you help us with this, please. How did the length of ICU stays during the pandemic compare to pre-pandemic non-Covid admissions?

A. The figures which I am told anecdotally would be that a normal ICU stay would have been about two to three weeks but in Covid times this could have extended for, you know, 130 days ... at ten weeks, so that the whole -- and the patients that were in the ICU were extremely unwell. So there was none of what might have been described as slightly easier ICU work. It was highly intensive and patients were there a long time with the additionality of families not being able to visit in the same way and the demands on this team to be providing that component of care that families would and the building of relationships because of that absence.

It was also more challenging because all of the communication with families was being done by phone or by video links. So the psychological and traumatic impact on staff was definitely highly significant.

Q. Can you tell us a little bit about the atmosphere in the ICU at this time, the collective feeling amongst the staff about the standard of care that they felt as if

they were able to provide?
A. The atmosphere changed with surges. In the first surge there was real challenge because this was a completely new experience for the staff in terms of how they had to work in full PPE in terms of trying to manage to have those communications and relationships with patients with significant mask-wearing and changing how they did things. And there was absolute fear. I mean, when you think about the society in general, it was anxious about Covid and we were asking staff to walk into situations where they were actually exposing themselves to it. There was an unfamiliarity with actually wearing PPE.

So there was -- it was a real fear of the unknown and a real unfamiliarity that made that first surge just very difficult in terms of the day-to-day work. But things -- as things changed and that bit eased, that stress eased, then it became more difficult because of the chronicity because of the repeated surges, because of the level of illness, because of the increased frequency of death in ICUs, these patients were very ill so the number of deaths was much higher. The management of end of life care was much more difficult.

So it was extremely -- and some of these staff weren't ICU staff. They were theatre staff who had been brought into an area again that they were unfamiliar

with. So the whole experience was just high intensity demand on a very chronic basis over a period of two years.
Q. At your paragraph 100 you say this:

"Altnagelvin Hospital faced particular challenges in the fifth surge which took place over December 2021 - February 2022. It was the second Christmas where the hospital was overwhelmed with admissions of patients with Covid."

We often hear that word "overwhelmed". When you use it in that context can you describe to us what that meant for staff and patients on the ground in the hospital at that time?
A. When I look back over the two years I think that was the lowest point for the staff group in Altnagelvin Hospital. I suppose we understood that level of concern that a staff felt when both nurses and doctors were coming to us as their directors and asking us about where they stood individually, professionally because of the fact that they felt they were not able to deliver care in the way that they usually would. And I, for example, discussed that with the General Medical Council, my nursing colleague would have discussed that with NMC because -- and that was to do with staff absence. That was to do with the fact that the wards

were so poorly staffed in terms of nurses and doctors as compared to usual, because Omicron, which was highly infective, it spread like wildfire. If you look at some of the reporting at that time the numbers of patients, people affected across Northern Ireland was described as extraordinary, up to 1 in 10. 1 in 10 people in some areas and that would have been our locality.

So we had significant losses of staff and I think some of that was even more difficult because at the time society was getting on with life as normal and yet within the hospital we were desperately trying to keep that still Covid-free because we still knew we had really vulnerable patients, we were still trying to keep staff levels at a level to deliver the best patient care that we could, staff were getting Covid. It was the most chaotic moment, I would say, in terms of our particular part of the country.
Q. What problems arose from the dissonance between what people were allowed to do outside and what both patients and staff had to follow in the hospital?
A. We were still in full Covid alert in terms of how -- what we expected of staff. So, for example, within the workplace staff would not be able to sit in the tea room together. There was still social distancing. There was still limited numbers particularly in the tea room and

yet the same staff, if they were following what was happening outside, could all have gone on a Christmas night out. They could all have gone out to a restaurant or to a movie together. So we were asking different things of them. Different things were expected of them in the hospital as compared to what was happening outside.

And it was really confusing for visitors who were -- mask wearing had stopped but as soon as they're into the hospital, there's hand sanitisation, there's mask wearing, there was potentially restrictions to some extent in terms of how many visitors might come. So they found it really confusing as well and it felt that they were two parallel universes going on at that point in time. There was Covid world, which was work, and then there was non-Covid world, which was outside.

So I think that tension was extremely difficult.

And then Omicron just was so infective that it went like wildfire through people groups and through staffing groups. So it meant that we were trying to balance and when staff got Covid or they were in contact with Covid, balancing the risk of bringing them back and then bringing Covid into the hospital or not bringing them back and having a really fragile workforce that might not be able to deliver the care that we wished.

So we were making very difficult risk assessment decisions every day.

Q. Next, please, infection prevention and control. Did the hospital always follow national guidance in respect of IPC measures or did it at times deviate?

A. Generally, we followed guidance but occasionally we applied what I would describe as a little bit of common sense. For example, guidance came through to downgrade some of our PPE just before Omicron struck and that wasn't to be predicted. So we delayed implementation of the new guidance until our community transmission rates dropped and we were content that there was -- that the rate of potential of transmission within the hospital had eased.

Q. At paragraph 41 of your statement you say this:

"The biggest challenge to implementing IPC guidance was concern in the early stages of the pandemic that guidance was developed around supply issues rather than safety and that safety measures being advised were inadequate."

Are you able to provide us with an example to illustrate this point?

A. I think that when we look back, the IPC protection or PPE protection was particularly for people who were in Covid areas but it wasn't really being prescribed for

people who sat outside those Covid areas. So the concern for a lot of nurses and doctors were that with the limited knowledge that there was of how Covid presented that they too should have had that protection and, thankfully, fairly quickly that did happen. But there was a sense that normally when you suspect that there might be a risk that you would use personal protective equipment and that wasn't possible at the start because of lack of availability.

And I would also point out that this wasn't just within health settings. Society at large was concerned for the safety of staff working within health. We got multiple donations, very generously, from people to provide us with PPE. So there was a collective understanding not just in health facilities that perhaps there wasn't enough PPE available to protect the staff in their day-to-day work.

Q. Did you ever perceive any difference between national guidance and that issued by the Royal Colleges?

A. Just the difference that I've described, that again that the Royal Colleges would at times have suggested that in the absence of knowing a patient was Covid positive or negative that some protection should be in place but at the same time they would have encouraged us to follow national guidance. So there was just that tension at

the start in terms of who needed PPE and who didn't. But, gratefully, we were seeing the new guidance coming that allowed us to provide protection for all our staff.

Q. Did that tension lead to a loss of trust and confidence in national directives on the part of your staff?

A. I think so.

Q. What, if anything, were you able to do to restore that?

A. What we tried to do was to continue to have conversations and to be as open and transparent as possible. I met -- on a weekly basis I had an open meeting for all doctors, senior doctors, and there were opportunities to just have conversations to support people in understanding what was possible and what was not possible at points in time.

Q. Next, please, visiting restrictions. It's right, isn't it, that the hospital developed a risk assessment tool to make decisions about whether to allow visits. Can you explain to us how that tool worked in practice?

A. I suppose I'd start by referring to the first visit. Visiting was very challenging and there was -- we weren't able to offer visiting but as we started to open up to visiting, the first visit was of a young woman to her husband, the father of her children, in the first surge and we were worried he was close to end of life. There was a lot of -- there was a lot to learn about how

to do visiting safely if we think about that as a scenario it was really important that this young woman was safe, that she did not contract Covid during the visit.

So you know it took -- we set up a system whereby a nurse, for example, met her at the door so that she could walk her through the hospital, through the Covid-safe pathways to support her in terms of putting on her PPE and bringing her into a very difficult environment which ICU always is but was even more difficult when all the staff were wearing PPE and to provide her with not just a support around Covid but just the emotional challenge of that visit to take her out of that ICU to make sure she took off her PPE safely, because one of the most critical moments when you are wearing PPE is to make sure you take it off properly because you are most likely to get infected at that point in time, and to take her safely off the hospital premises.

So there was a lot of learning for us in that about what needed to happen to keep the visitors safe and what sorts of levels of staffing we needed to support someone on a visit. That's what we gathered. It was through the ethics committee that we sat and we did a template to try and make sure that we could offer

visiting equitably within the facility because some days it would be easier to do because there would be staff availability, there would be less ill patients, and other times it would be more difficult. So that's what we did.

Q. In your view, did the tool allow the hospital to find the right balance between maintaining a Covid-safe environment and the emotional cost that visiting restrictions could cause?

A. Yes, absolutely. Absolutely. It was a tremendously supportive tool to staff and it also was helpful, I think, in terms of conversations with families because they understood the rationale, they were beginning to understand the risks that had to be managed to allow for safe visiting.

Q. Was the risk -- was the tool used to approach the question of visiting in a maternity setting or did the hospital approach that question slightly differently?

A. I'm back to memory now. I can't remember. Apologies. I can't remember.

Q. Do you recall whether in the early stages of the pandemic there was an absence of national guidance on visiting in a maternity setting?

A. I remember our guidance. I remember the local guidance -- I remember the regional guidance in visiting

our maternity unit. I can remember that and it really was that they were only allowed to visit a partner available -- sitting with them through labour. I remember there was significant restrictions and I had some discussions with the team in preparation for the Inquiry as to how they managed that.

Q. Can you tell us anything about the impact of visiting restrictions in that particular context on patients?

A. Maternity was particularly difficult because pregnant women were all highly vulnerable. So we were -- again, we were challenged to balance our duty of care to every woman who came into the hospital to ensure that they were safe and within the trust we lost one mother and that felt like one mother too many. So it was absolutely critically important that we kept them safe but then we were really mindful of the emotional journey of anyone in terms of a baby and the importance of their partner within that.

So I know that what happened within the scans were partners did not routinely attend that there was an arrangement that they would be outside and if there were any difficulties that the partner would be invited in to support the mother if there was bad news to be broken and I understand that partners were allowed to be with the mothers through labour and that was our compromise

as best we could, recognising the particular vulnerability in pregnant women and for their babies.

Q. You mentioned the ethics committee. I think it's right that that was established on 27 March 2020 with you as its chair?

A. Yes.

Q. In broad terms, can you help us with what the purpose of that committee was?

A. If we think back to 27 March 2020 and we had a look towards experiences in Europe as to what we might expect in terms of demand and the pandemic, there was a crushing concern that we would be in a position of needing to ration care and how that might happen and some very difficult clinical decisions might have to be made.

So we decided to start having those discussions as early as possible so we opened up our ethics committee. The ethics committee was extremely important in terms of bringing a wide range of people to the table in terms of having discussions. So we had our chaplains, we had lay people, we had academics, we a non-executive director, and we had obviously some trust staff. And it really was with the purpose of ensuring that we did the right thing and ensuring that we were supporting clinicians on the ground whose anxiety levels were extremely high

about this aspect of potential decision-making in the future.

It was to -- it was a place to bring dilemmas, it was a place for anyone to bring questions and it was for us to be on the front foot in terms of developing some tools that might be helpful to them in the moments of crisis.

Q. Some might think that clinicians have to make all sorts of difficult decisions all the time. Can you help us understand how a national decision-making tool about the rationing of care might have helped those working in the hospital?

A. Clinicians do -- a lot of what we think in terms of or talk about in terms of difficult decision-making in Covid, as you rightly say, is what happens daily but Covid intensified all that and asked us to really look at it and added layers of complexity. So it was really important that we dealt with that.

I think it felt like an extremely heavy burden for a clinician to carry on their own and that's why it was really important for us as an organisation to ensure that those clinicians were supported and we did that by developing some tools and developing an emergency decision support group should they have been in that particular acute position of trying to determine who

should receive care. I think it's an area that needs -- in peace times, we talk about peace times, non-Covid, non-pandemic times. It's an area that we really should be doing work on now rather than waiting until we get into the eye of the storm and I think that we can never have too much guidance, whether it's regional or national, in terms of helping us to explore these difficult topics and help us and direct us and guide us to do the right thing by each individual patient.

Q. I think it's right that, as it transpires, the services of the emergency decision-making support group were never in fact needed.

A. They weren't needed but some of the documentation that we developed around it was just really helpful for clinicians when they were working their way through some clinical decision-making. But thankfully it was actually not needed.

Q. Having gone through the process of developing documentation in this area, are there any specific references that you would like this Inquiry to consider?

A. I don't quite understand the question.

Q. In the context of creating a decision-making tool in respect of the rationing of care, having created that at the hospital within the trust, do you have any insight into --

A. Sorry, you just froze.

Q. Having created the decision-making tool about the rationing of care, do you have any insight, any recommendations you would like the Inquiry to consider about what worked well?

A. About what worked well? I think the security of knowing that there was an emergency decision-making support team being there was critical to free the minds of our clinicians up to look after patients without having that additional worry. We also developed what was called a hospital treatment escalation plan which was a document which is in keeping with best practice around anticipatory care planning which had not developed fully in Northern Ireland.

There's been more development since Covid. It was developed with reference to best practice and based on a template that had been used in the any big trust and I think that it was a really important tool as a support to doctors to do the right thing. We want documentation that prompts people to do the right thing and I think that's what it did. It was a document that we were very concerned as the ethics committee to make sure that it was for a single episode of NLS(?). It wasn't our carte blanche, this is what's going to happen, to have every admission have its single. It was tested out by senior

clinicians. It was -- all these refs -- the decisions that came out of it are always referenced using the clinicians.

So there was a lot of very good stuff in that and there was a real support to junior doctors to make sure they were doing best decision-making in conjunction with patients and their families in a very complex time, and I think I would definitely recommend that that would be available to support all doctors in all hospitals at times like this.

Q. Considering the picture more widely about the support the trust introduced for staff, can you tell us a little about the measures that were introduced to support their psychological needs?

A. I suppose my background is psychiatry so I thought it was extremely important, as did many in the organisation, that we look after not just protect our staff in terms of infection, prevention, control but also be very mindful of the level of stress and anxiety, trauma that they were going to experience in a pandemic. So the first that's happened, which was critical, was we had two senior psychologists who took a lead role in helping develop a raft of interventions, some of which were linked to the regional initiative of having a psychological helpline, others that were related to

team debriefs, crisis interventions, all of which were delivered by the psychologists plus a wider team pulling on skills from our mental health services.

There were already well-being programmes within the trust and they were expanded upon. There's a work stream within -- called TWIST West, which was all about really trying to help people just do well in the middle of the crisis.

So there was a lot of work in terms of trying to support staff in IC work in circumstances that were completely unexpected, and that's extremely critical in terms of delivering good patient care. If your staff are well they will do a good job. If your staff are stressed and anxious they will not be able to be there for patients as they would normally like to be. So it was part of the whole approach to patient safety and quality of care.

Q. Finally then, Dr McDonnell, are there any lessons and/or recommendations that you would like to share with the Inquiry based on your experience at Altnagelvin during the pandemic?

A. I think I'm going to be repetitive and say things that have already been said but I think the most important one is the workforce and the baseline from which we launch ourselves into a pandemic. I think that that's

absolutely critical. And I think the second one is, and it's been talked about, pandemic preparedness. We need the PPE. We need things like the visiting guide. We need some of that -- those ethical performers that we were speaking about. We need those things in place before another pandemic hits.

I think the evidence thrown(?) up but I think it's really important to understand the impact of the pandemic on elective services in a crisis, and the resources are eaten up by the crisis, and the non -- patients not in absolute peril get left behind. So I think there's something about how we think about -- how we manage elective services.

And I think the fourth one, I would obviously be passionate about is that we really need to think about our staff, how we look after staff and, you know, if we look back on those two years, in the midst of all of that, there was no opportunity for staff to rest. Staff did not get an opportunity to rest. We launched from surge to surge and then we launched into reset and rebuild and we need to think seriously about how we recruit staff and then how we retain them, how we keep them well.

MR MILLS: Dr McDonnell, thank you.

My Lady, that's all I ask.

LADY HALLETT: Thank you very much.

Mr Wilcock.

Questions from MR WILCOCK KC

MR WILCOCK: Dr McDonnell, I represent Northern Ireland Covid Bereaved Families for Justice campaign and I should say, in the spirit of full disclosure, that Altnagelvin was the hospital I was born at and the only hospital I'm lucky enough ever to have been an inpatient in.

I have been granted permission to ask you questions on two subjects. The first is the hospital's relative success in combating nosocomial infection during the pandemic and the second is the approach within the Western Trust's ward DNACPR orders. Can I deal with the first first.

Can we please have on the screen -- and you have it in your tab 7 at page 4, doctor -- INQ333416864, page 4 as paragraph 2.8. I don't know, doctor, does this come up on a screen in front of you?

A. It does but it's in small writing, so I can't actually read it.

Q. That's not helpful. As I said, if you have your papers, it's in your tab 7 at page 4.

A. That's better. 2.6.

Q. 2.8 is what I'm going to look at.

A. Sorry, 2.8. Yes, appreciate that. I've got it now. Yes.

Q. This is an extract from a 2021 report that you will be familiar with?

A. I'm familiar with the report.

Q. We can see, can't we, that the hospital was lucky enough to have a 72 ward block opened right at the start of the pandemic. I'm not sure whether it's April or June 2020 but it says June in that document. That's correct, isn't it?

A. That's correct. Actually, it was in April. You're correct.

Q. What I wanted to ask you was whether you agreed with the conclusions in that paragraph that that undoubtedly contributed to the hospital experiencing what the subgroup described as, in a different part of the report, lower, less frequent, less complex and less sustained rates of nosocomial transmission up until the report was written in May 2021.

Do you agree with that proposition?

A. I do agree that it absolutely contributed. We were fortunate to have a new build that opened up which had single rooms, better ventilation than the older parts of the hospital, and that certainly contributed to the lower level of nosocomial infections.

But I also think -- and we and a little bit of a look at this because we certainly were a bit of an outlier in terms of having less nosocomial infections and less death for those who suffered nosocomial infections. I do think that there were contributing factors, such as the manner in which we worked through IPC around infection prevention control strategy which was really about making infection prevention control everybody's business. It wasn't just for a small team; it was how we networked and how we got everyone on board in realising it was our business. And the good news might be -- for you might be -- that there's a continued decrease. It still continues to be an outlier for other non-Covid hospital-acquired infections. The west continues to be an outlier in terms of performing better, which I think is a combination of estate, many other things and also how we think about our IPC practice.

Q. Thank you for that.

Can I come on to the IPC practice during the pandemic because, in your statement, you identify two areas on top of the common sense deviations you've told us about where staff at Altnagelvin appear to have taken measures to counter nosocomial infection which had not been fully reflected in the IPC guidance.

The first one I'm referring to is at paragraph 47 of your statement. You state that staff recognised risk linked to ventilation "... in the very early stages" and that this, and again I quote from your statement:

"... was highlighted for them as they re-purposed theatre spaces as part of the first ICU surge plan in March 2020."

Then the second example where it may be thought that you are identifying areas where staff appear to have gone beyond IPC guidance is at paragraph 50 where you seem to identify that for testing your trust adopted a practice wider than guidance and, as a result, identified Covid positives among staff who would have fallen outside the regional definition for testing.

So I suppose, assuming that I'm right, and that they were beyond the guidance at the time, is it a matter of concern to you that, in order to take the effective steps you've described to reduce nosocomial infection, your trust felt it necessary to take what you thought were commonsense steps and steps which could be felt to amount to departures from the IPC guidance?

A. I think there's always a tension in terms of a pandemic where there's a mixture of approaches in terms of a guide, a command and control approach to guidance or a guidance that is given with a permission to have some

level of nuance depending on local intelligence experience and concerns.

So I suppose sometimes we take the liberty of expecting that people would forgive us if we made some decisions around how -- what we needed to do all in the spirit of keeping patients and staff as safe as possible. And I suppose that piece that you refer to, in terms of having test a small cluster of staff in the early days before testing, tracking and trace was all in place, was just overarching concern that the narrow definition of Covid in the first instance couldn't truly reflect a virus because no virus would behave in such a -- would behave so perfectly as to only have three potentially presenting symptoms. And it helped to inform us and keep us far from complacent when we were looking at staff and understanding that they could carry Covid and be asymptomatic.

Q. Thank you for that answer, doctor.

Can I turn to my second topic, which is DNACPR because many members of the group I represent have made clear that in their experience their relatives were "given up on" and simply abandoned to their fate.

In paragraph 96 of your statement, you describe the development of a trust decision-making tool to provide additional support to decision-makers who were

working through the pandemic and what you have described as a pervasive climate of fear of scarcity. We're going to hear expert evidence on this topic on Wednesday but do you think that, notwithstanding the guidance that you developed, that pervasive climate of fear and of scarcity resulted in subconscious applications of the clinical thresholds the guidance expected clinicians to apply to DNACPR decisions?

A. I can't talk in generalities but I can talk about what happened within Altnagelvin Hospital. And what I've talked about in terms of our ethics committee, of me meeting regularly with doctors, was to really try and alleviate anxiety so that people would continue to make good clinical decisions and not move into that space that you're describing where they get so anxious about the future.

But I would really want to reassure people about Altnagelvin Area Hospital that there was a really tight senior consultant decision-making group that met every day across every aspect of patients who had Covid, whether they be in older people's service, whether they were in ICU, whether in a respiratory ward or in general medical wards, and they reviewed all those patients as a collective in terms of determining were they placed in the right pathway of care, whether they were improving,

whether they were deteriorating, exactly.

So it was very nuanced. Within Altnagelvin Hospital, it was very nuanced in terms of making sure that all patients were getting the best care in the right place at the right time. I'm recognising that was dynamic but sometimes patients got better, sometimes patients got worse, and that you reframed your expectation in terms of the patient pathway in terms of the patient's own clinical progress.

So I can't speak for other hospitals but I can speak with confidence around how that decision-making happened in Altnagelvin because of the strong clinical leadership in terms of the consultants who led those services and whom I met on a regular basis, and who got all those concerns to our ethics group which met on a weekly basis or twice-weekly at the acute stage of the pandemic when I required.

Q. Dr McDonnell, we understand your answer. It's very clear. But, following on from that, can I just ask you my last question which is that at paragraph 97 of your report you point out, in keeping with what you've just said, that DNACPR was a topic regularly discussed at the trust's ethics group and that, to your knowledge, you say there were no issues raised through incident reporting, complaints and raising concerns in relation

to changes to practice in applying DNACPR.

I just want to ask you this: is it possible that the reason you weren't aware, in spite of the efforts you made to find out, of any issues in relation to the application of DNACPR within the trust is because the system for complaining about or challenging individual's DNACPR issues was not accessible to patients or effective in practice?

A. You know, I appreciate that things could be missed but I suppose that all complaints -- I sat on -- I chaired a group every week that reviewed every single complaint that came through to the hospital, constantly looking for trends that related to -- relate to anything but -- and, in particular, we had a group looking specifically at anything relating to Covid.

The group is not just myself. I chair a group with senior professional leads and directors every week looking at every complaint and looking at every incident that comes through and it's for that purpose, looking to see is anything going on that we need to know about.

But I'm not saying that perhaps people didn't understand just to use the complaints system to help us know what was going on on the ground. I would wish to assure people that we were constantly looking to get feedback to make sure that we were doing the right

thing. It was part of our strategy as to how to manage a pandemic.

MR WILCOCK: Dr McDonnell, thank you very much for your answers.

My Lady, that's all I ask and I think it's 4.30 exactly.

LADY HALLETT: Perfect timing, Mr Wilcock. Thank you very much indeed. I think that completes the questioning for the doctor.

Dr McDonnell, thank you so much for your help, I'm really grateful, and obviously for all the work that you and your colleagues did during the worst parts of the pandemic. Thank you.

10 o'clock tomorrow, please.

(4.30 pm)

(The hearing adjourned until 10.00 am on Tuesday, 18 September 2024)

I N D E X