Wednesday, 13 November 2024

(10.00 am)

DR ANDREW GOODALL (continued)

Questions from COUNSEL TO THE INQUIRY (continued)

LADY HALLETT: Ms Nield.

MS NIELD: Dr Goodall, yesterday we had just looked at the data from the sitrep of 30 March. We're going to look now at the sitrep data from a week later, 7 April. But before we do that, could we have a look at the information that you were passing to the local health boards on that same day, 4 April 2020.

Can we go to table 7 that's at page 171 in your witness statement, please.

You explain that you wrote to the local health boards on 4 April to discuss their capacity plans and included this table at page 171 in your letter to them.

This is in INQ000485721.

So this sets out the all-Wales requirement: 900 beds would be required in critical care, is that right, and 10,000 additional acute hospital beds?

A. Yes, that's correct. This was based on the work that SAGE had undertaken that we had been reviewing since early March. There had been some refinement of it but we were using that methodology and just translating it into what that would mean for Wales based on the

reasonable worst-case figures.

Q. And numbers have been allocated for each of the local health boards. Had these numbers come from the local health boards as to what they were going to be able to provide, or had this been sent out to the local health boards as these were their targets?

A. Yes, health boards had been working on the ways in which they could expand their own capacity on a local basis, but this was very deliberately a national approach to say what we believe the numbers should be for planning purposes.

The reasons for that was to just give support to our hospitals across Wales, to the clinical teams to know what their planning assumptions were, to prevent people spending too much time trying to do a whole range of local assessments. Because we were using the standardised methodology of SAGE at that time, it was very reasonable for us to direct that at an all-Wales level and it was to give clarity. You'll notice that there is one health board which wasn't allocated any beds; that's simply because of its particular function.

Q. They don't have an acute hospital in Powys.

Sorry if I haven't quite understood, are you saying then that these were figures that were given to the local health boards rather than figures coming from

the local health boards as to what they could achieve; is that right?

A. Yes, these were planning figures that we set at a national level which we wanted all health boards to give us plans and proposals for.

Q. Thank you.

So at that stage 900 critical care beds were going to be needed in total, that's including the existing beds; is that right?

A. Yes, that's correct.

Q. Thank you. So we've seen that that's changed somewhat from the figure in the TAC advice of 15 March when 1,650 ICU beds were projected to be needed, and we can see here that this says reasonable worst-case scenario 40%. So is it that it was on a different modelling basis that -- is that why the figures have changed from 15 March?

A. There had been some refinement of the SAGE model through March and we were just using the latest version. I think this was based on version 2.3 at the time. You'll recall that the early March modelling was talking about a figure of around 1,500 critical care beds and this was reflecting a reduction in that. But the 40% reasonable worst-case figure that we were using was based on an assumption of 40% compliance of a population

with control measures, and it was expecting a conversion to hospital beds of patients needing hospital beds of around 4.4%. And at that time there was an understanding, an expectation that about 30% of patients who were hospitalised would require critical care. Obviously those assumptions changed over time as we learnt more about the virus but they were the SAGE modelling assumptions at the time.

Q. Okay. The Inquiry heard from Public Health Wales that 40% reasonable worst-case scenario did not mean 40% compliance or 40% of the population complying with non-pharmaceutical interventions, it meant 40% of the reasonable worst-case scenario. Do you know which is correct, which interpretation of 40% reasonable worst-case scenario?

A. Figures were introduced here and my statement is clear on this: these were based on the 40% compliance with the control measures. And that's referred to in my statement.

Q. Thank you.

Can we have a look then, please, at the data that you collected from the local health boards of 4 April. This is shown at page 167 of your witness statement. There are some changes in terms of the categories of data that are collected here compared to what we saw

1 yesterday from 30 March 2020.
2 So we can see that the data collected here is
3 invasive, ventilated beds is split into: in a critical
4 care environment; in a hospital but outside of
5 a critical care environment; and temporary beds
6 providing invasive ventilation outside of a hospital
7 building.
8 And the total invasive ventilated beds have gone
9 up somewhat to 356 beds.
10 If we can look at the box below that, we now see:
11 the total number of designated Covid-19 hospital beds;
12 non-designated Covid-19 hospital beds; total hospital
13 beds, which is 6,786; temporary beds providing hospital
14 care outside of a hospital building; and total other,
15 and it says "(non-invasive ventilated) beds", so that
16 seems to be beds that do not provide invasive
17 ventilation rather than bed that are providing
18 non-invasive ventilation; is that correct?
19 **A.** That's correct.
20 **Q.** So we don't see here any beds that are providing
21 non-invasive ventilation and we don't see here beds that
22 are providing CPAP, which we did have on the 30 March.
23 Why have those categories been removed when they were
24 there the week before?
25 **A.** I'm not sure why they were removed, whether this was

1 just an aggregate that we were able to pull together.
2 I would assume that the data was still being reported
3 underneath but I think there was a particular focus on
4 the intensive ventilated bed capacity that was required.
5 We were still able to track and did introduce later ways
6 in which we understood where patients receiving
7 ventilation were outside of the critical care
8 environment. But I would need to check. I can't recall
9 from my statement that that is complaining why that was
10 the situation.
11 **Q.** I don't think it's set out in your witness statement,
12 Dr Goodall. We heard from the medical director of
13 NHS England last week about why categories of data were
14 collected and the type of data that was collected in
15 relation to hospital beds, and the approach in England
16 was less to do with the physical location of the bed and
17 more to do with the clinical capabilities of the bed and
18 the kind of support that could be given, so whether it
19 was staffed, whether it had equipment and consumables,
20 the staffing ratios that would designate that either as
21 a level 2 or level 3 critical care bed, whether it had
22 oxygen capability, whether that was high or low flow
23 oxygen capability.
24 But that data doesn't seem to be collected here.
25 Did that change at any point or was this as granular as

1 the data got?
2 **A.** No, the data was changing as we continued responding to
3 the pandemic. So, for example, later on in April we saw
4 further changes where we were able to bring in the field
5 hospital data. Because during March we had been
6 assessing the numbers of ventilators, non-invasive
7 ventilators. We'd been tracking oxygen support, for
8 example. Rather than have separate submissions, we were
9 able to draw those into the sitrep reports as well as we
10 had that more broad view of things that were happening
11 on the ground and that were helpful to us to understand
12 at a national level.
13 **Q.** All right. But certainly at this point, on 4 April,
14 that level of data isn't being collected.
15 We can see that surge capacity is shown here, but
16 already in the total invasive ventilated beds -- which
17 isn't in the surge capacity section -- 356 beds, that is
18 the expanded number of beds, isn't it? That's not the
19 baseline, how many you started with?
20 **A.** That is the number that we were planning that we could
21 expand to, given the requirement for 900 and what had
22 been 1,500. As I explained yesterday, it was always
23 really important to set that in the context of what was
24 the normal critical care capacity that was available in
25 Wales, and that was at 152.

1 **Q.** That doesn't appear on this table, does it, it doesn't
2 show the original number of beds as 152. It doesn't
3 differentiate, does it, even between bed that are
4 functional and ready for use and beds that are
5 theoretical in that they exist but they're not
6 necessarily staffed or with an oxygen supply for
7 example?
8 **A.** No, indeed we would know those number of beds within the
9 health boards' own reports, they would understand their
10 baseline levels as well, but as the proforma moved we
11 did introduce that, and also I was very clear in the
12 personal updates that I chose to give from a very early
13 stage of the pandemic, these weren't the official sitrep
14 reports but it was me giving a sense of how the NHS was
15 responding. I was always very clear in those reports to
16 refer to the baseline for critical care beds for example
17 so that ministers would understand actually that stretch
18 on the system and the pressures that were being
19 experienced across the hospital.
20 **Q.** Is it righted that it was the minister in fact who asked
21 to have that information included, wanted to know the
22 baseline and how much over baseline it was? Is that
23 right?
24 **A.** Yeah, the minister was aware of those numbers from
25 previous involvement when we were expanding critical

1 care beds in Wales before the pandemic. He was also
2 aware, because I was reporting on that to him in my own
3 more personal reports that were being submitted as well
4 and he felt that was a helpful addition just to make it
5 very clear to wider colleagues as well beyond just
6 himself and the First Minister of course.
7 **Q.** Can we stick with this table then and what's shown on
8 this table. Who is this table for?
9 **A.** This table was being reported in to us to have
10 a national summary. It was underpinned by local
11 hospitals --
12 **Q.** But who was it for? Who is supposed to be looking at
13 this?
14 **A.** This was for us in NHS Wales but it also satisfied the
15 reporting that was able to feed up to ministers to have
16 an understanding of the performance of the NHS across
17 Wales.
18 **Q.** So it's not clear at a glance from this which beds are
19 ready to be used, which beds are in surge capacity,
20 which beds are purely theoretical, how many patients are
21 receiving CPAP, how many additional beds are available
22 for patients who need mechanical ventilation. None of
23 that information is immediately apparent in looking at
24 this, is it?
25 **A.** It's not immediately apparent from this but we would

1 have expected that health boards would have that --
2 their own understanding when they were submitting this
3 information. And in terms of the immediately available
4 beds, they would be represented by the totals that were
5 on the left-hand side in terms of the total numbers that
6 are available, and the additional capacity available
7 within 24 hours, 24 to 7 days, and after 7 days, they
8 were reflecting that they were beds that we could step
9 up into based on need if they needed to be commissioned
10 by the local health boards and that was the national
11 picture on those.
12 **Q.** All right. Can we have a look at the way the local
13 health boards were dealing with the data that was being
14 collected and their access to that data. You've been
15 provided with the witness statement from the Chief
16 Information Officer from Cwm Taf Morgannwg Health Board.
17 I don't think we need to go to that witness statement
18 itself INQ000409575. And the Chief Information Officer
19 is quite critical of the limitations on the data that
20 was collected by the Welsh Government particularly in
21 relation to CPAP. He says this:
22 "The recording of CPAP use was never resolved in
23 Wales. As a result the sitrep reports were never
24 relied upon by anybody undertaking analysis. Rather
25 than addressing the shortcomings, the publishers

1 presented the numbers with a warning on that they
2 included suspected numbers ... The absence of
3 reliable CPAP data meant that we went through the
4 first and second waves unable to evidence our
5 preparations as to whether we had enough CPAP machines
6 and oxygen to meet need ... The lack of data
7 diminished the ability of clinicians to use data to
8 audit and compare the effectiveness of care for Covid
9 patients. Better data would potentially have helped
10 care optimisation or have helped the clinical teams to
11 make changes to how they delivered care earlier."
12 Dr Goodall, do you think those are valid
13 criticisms of the data collection by the Welsh
14 Government?
15 **A.** I think they are valid criticisms of the data in some of
16 the summary and aggregate reports we had. There were
17 other ways in which we could access that information.
18 So, for example, the references that Mr Nelson has made
19 to oxygen and CPAP, we were assessing those through the
20 planning and response structures and able to draw on
21 those. And actually after the oxygen assessments that
22 had been undertaken, given that they had been escalated
23 by the NHS Wales and we were involved in supporting the
24 plans for those, we were able to maintain a group that
25 was overseeing those oxygen arrangements that had

1 a particular focus around our estate's infrastructure as
2 well, so -- and whilst the summary and aggregate
3 information may have frustrated some of the
4 understanding there were other sources of data that were
5 available that we were able to pull in from those
6 operational experiences within the NHS in Wales as well.
7 **Q.** What about the point that's made that it was hampering
8 the ability of clinicians to assess what was the most
9 effective form of clinical support for Covid patients?
10 Data wasn't just for use by the Welsh Government in
11 terms of counting how many beds were there. Data has
12 a number of important uses, doesn't it, during
13 a pandemic?
14 **A.** Data has many important uses and certainly from
15 a Welsh Government perspective reporting into the Health
16 and Social Services Group we wanted to make sure that we
17 had subset of data that was helpful to us at a national
18 level which we were able to collect routinely and
19 without inappropriate impact on the system. All of the
20 operational data that is normally in use by the NHS in
21 Wales were still available in terms of that local use.
22 What was helpful to us was the way in which our
23 clinical networks in particular were able to step into
24 some of the understanding of this data, so, for example,
25 through our national respiratory lead or through our

1 critical care network we were able to make sure that
2 there was a more refined understanding of some of that
3 data and, again, there was a way in which could be fed
4 into us as well.
5 **Q.** Can we have a look at the pressures on the system in
6 terms of critical care occupancy during the pandemic,
7 please, and can we have a look at a graph that's been
8 prepared, I think, by the Welsh Government. This is on
9 page 182 of your witness statement, figure 7. And it
10 shows, I think, weekly patients in invasive ventilated
11 beds. And we can see there that the black lines show
12 confirmed Covid patients, the brown lines suspected
13 Covid patients. Is there any reason why confirmed and
14 suspected Covid patients have been split up in this
15 data? Would they not be cared for in the same
16 facilities?
17 **A.** Yes, they were cared for in the same facilities but it
18 was just allowing us to understand that for some
19 patients there was a time lag, even if it was short,
20 about having confirmation of their test but they were
21 treating as if they were Covid patients. On occasion
22 you may end up with a patient who was suspected to be
23 Covid where the test result did not confirm that, yet
24 they still needed to have access in critical care,
25 of course, but it just allowed us to understand some

1 differences around the data. So confirmed was really
2 the core actual position. It allowed us to understand
3 the surveillance of the virus, if I can put it that way.
4 **Q.** Well, if I can stop you there. Can we have a look at
5 what we're seeing on the graph. This is split up
6 non-Covid and Covid patients, so the number in invasive
7 ventilated beds would be the combined number, I think.
8 These are numbers rather than percentages. Did the
9 Welsh Government ever have data on the percentage of
10 available beds in intensive care that were occupied
11 whether by Covid or non-Covid patients?
12 **A.** Yes, because we had the data, we were able to track the
13 percentages as well.
14 **Q.** And did you have that information by hospital and local
15 health board to show whether there was pressure on
16 capacity in particular places?
17 **A.** Yes. Yes, we did. The aggregated summaries you showed
18 earlier were all supported by individual health board
19 and hospital positions.
20 **Q.** All right. Can we have a look, please, at your witness
21 statement at page 183. This is paragraph 455. The
22 final sentence there says:
23 "In terms of whether critical care capacity or
24 general bed capacity was reached or exceeded in any
25 local health board or individual hospital [Digital

1 Healthcare and Wales] will be best placed to confirm
2 this information."
3 Why does the Welsh Government not have that
4 information?
5 **A.** We had it at the time as we were going through the
6 pandemic and receiving it on the spreadsheets and the
7 databases. I think that's just a practical data
8 issue for DHCW to provide it based on holding all of the
9 information throughout the whole period of the pandemic,
10 they have it accessible on their database.
11 **Q.** Does that mean you --
12 **A.** We had it at the time.
13 **Q.** -- had it at the time but you don't have it anymore?
14 **A.** That's correct.
15 **Q.** Why is it that the Welsh Government hasn't retained that
16 data?
17 **A.** I don't know why that is the case in terms of responding
18 to the Inquiry. I would have to check outside, I'm
19 afraid, with colleagues supporting me but we did have it
20 at the time because -- *(unclear: multiple speakers)*
21 **Q.** You did have it at the time --
22 **A.** -- had the individual information for hospitals, for
23 example, from those spreadsheets and the way the
24 information fed through.
25 **Q.** Do you know how long it was kept for or at what point

1 that data was disposed of?
2 **A.** I'm sorry I can't comment on that. I would have to
3 check with the team supporting the responses to the
4 Inquiry, I'm afraid. I'm very happy, of course, to do
5 that today.
6 **Q.** All right. Perhaps we can move on to CRITCON levels
7 because that was another way of tracking capacity and
8 the pressures on capacity in critical care. Is it right
9 that CRITCON levels were recorded on the unscheduled
10 care dashboard for Welsh Government data only from
11 December of 2020; is that correct?
12 **A.** Yes, that's correct.
13 **Q.** How was Welsh Government then collecting information on
14 the pressure in critical care prior to December of 2020,
15 why was it not recorded until then?
16 **A.** We were receiving the daily updates that allowed us to
17 track in data terms the pressures on the system. At the
18 same time we were able to link regularly, usually daily,
19 on occasion through the day with the critical care
20 network that was made up of our frontline clinicians.
21 There is a national clinical lead for critical care, as
22 well, and a team supporting them and they were also
23 involved in supporting us with some of the operational
24 requirements of the system in Wales. They're not an
25 operational unit themselves but during the pandemic they

1 really helped to make sure that there was a more direct
2 understanding of the pressures that were being
3 experienced across critical care but we felt that the
4 inclusion of CRITCON from December, particularly as we
5 were moving through the second wave and with the
6 pressures that the NHS were experiencing were a further
7 helpful way of understanding those pressures across
8 Wales.
9 **Q.** Would you accept the recommendation that was made by
10 Stephen Mathieu of the Intensive Care Society it would
11 be beneficial for CRITCON to be used across Wales in
12 future pandemics or at times of extreme for example
13 winter surge pressures?
14 **A.** Yes, I would agree with that. One of the reasons it
15 works very well in England is an issue of scale, because
16 of the coverage of the very many critical care units.
17 Because we have smaller units in Wales, and with the
18 Critical Care Network they do liaise with each other
19 very frequently, but I do agree that having the CRITCON
20 status available again just provides another level of
21 information beyond the data.
22 **Q.** You touched on the fact that the Wales Critical Care and
23 Trauma Network is not an operational network so it's not
24 a critical care transfer network in that sense.
25 Were the Welsh Government informed if local health

1 boards had to transfer critical care patients out to
2 another hospital or local health board during the
3 pandemic?
4 **A.** Mostly if that was happening that would be
5 an operational issue in respect of mutual agent support
6 happening between individual health boards and indeed
7 individual hospitals. There were escalation mechanisms
8 available, daily bed calls. The Critical Care Network
9 itself was meeting and often they would be brokered
10 through that. They were not happening very regularly
11 but they would tend to be held at that more operational
12 level within the health boards themselves.
13 **Q.** So is the answer to that, no, the Welsh Government were
14 not informed if local health boards had to rely on
15 mutual aid?
16 **A.** We were not informed as part of the process but we would
17 often have team members from the Health and Social
18 Services who would be sat on those calls, but the answer
19 would be no in terms of the operational pressures.
20 **Q.** So is it right that the Welsh Government didn't ask the
21 local health boards to keep them informed of whether
22 they were having to rely on mutual aid from neighbouring
23 health boards? Would that not have been a useful piece
24 of information to have had?
25 **A.** It would have been a useful piece of data and

1 information to have. Often those type of experiences
2 were reflected in the chief executive calls or with the
3 medical director calls and we would have a sense of the
4 way in which, certainly in the first wave, the virus was
5 spreading across South Wales. But that would be useful
6 information to receive, I agree.
7 **Q.** Finally, in terms of numerical data that was collected
8 by the Welsh Government during the pandemic, do you
9 think that the Welsh Government were collecting
10 sufficient data at the right level of granularity during
11 the pandemic? Do you think this is an area where the
12 Welsh Government could have done better?
13 **A.** We were, in the very early stages, trying to ensure that
14 we could draw on appropriate data that was in use by our
15 local hospitals and by our local health boards across
16 Wales, and indeed some of the other sectors.
17 I do agree that the pandemic has given us learning
18 about the level of detail that is useful to use which
19 didn't provide a burden or pressure on the system but
20 really brings to life the experiences across the system.
21 I think the data doesn't just tell you the experience,
22 even though we can track and see how things are
23 changing, even day-to-day. It's really important that
24 you build in wider experiences as well. And it was why
25 it was so important to have other ways of talking to our

1 hospitals, to our frontline clinicians, to our executive
2 teams, to make sure that we had a genuine understanding
3 of the pressures that they were experiencing, that their
4 staff were experiencing as well. I think we enabled
5 that through national calls, through our clinical
6 networks in Wales, to try and, I hope, bring that more
7 to the surface than just the data itself.
8 **Q.** Could I ask you, please -- I think you've been provided
9 with the evidence of Professor Fong, who explained to
10 the Inquiry that he was involved in a scheme of peer
11 support visits to intensive care units to see really the
12 reality on the frontline, going beyond the numerical
13 data to the experiences of staff in very pressured
14 intensive care units.
15 Professor Fong explained that he had received
16 requests from other nations to carry out similar visits
17 but he said he wasn't aware of any similar scheme taking
18 place in other nations. Were you aware of any request
19 for peer support visits coming from any hospitals in
20 Wales where they wanted a scheme like Professor Fong's?
21 **A.** I'm not aware directly of a request for a similar
22 scheme. We were receiving advice from our clinical
23 networks in this respect, particularly the Critical Care
24 Network, but often that was a way of hearing that voice
25 very directly anyway, but I'm not aware of any requests

1 for a similar scheme given that I've obviously had the
2 opportunity to read and seek Professor Fong's evidence.
3 Q. In the event of a future pandemic would you see the
4 benefit of a scheme like that in Wales?
5 A. I would, absolutely. I thought it was very powerful
6 evidence and I do believe that would definitely help us
7 to have even more of that frontline experience
8 demonstrated to us and be able to use it in that very
9 effective way.
10 Q. Moving on from data now. Can we look briefly at the
11 steps that were taken by the Welsh Government to
12 maximise existing capacity in the NHS in Wales. I think
13 it's correct that on 13 March the Minister for Health
14 and Social Services published a ministerial statement
15 setting out a framework of actions for the healthcare
16 system in Wales.
17 Can we have a look, please, at that ministerial
18 statement. And if we can look at the first four of
19 those bullet points, please. Can we look at the
20 numbered points. Thank you.
21 So this was where the local health boards were
22 being advised to:
23 "1. Suspend non-urgent outpatient appointments
24 and ensure urgent appointments are prioritised.
25 "2. Suspend non-urgent surgical admissions and

1 procedures (whilst ensuring access for emergency and
2 urgent surgery)
3 "3. Prioritise use of Non-Emergency Patient
4 Transport Services to focus on hospital discharge and
5 emergency response."
6 And:
7 "4. Expedite discharge of vulnerable patients
8 from acute and community hospitals."
9 I think it's right that that wasn't a ministerial
10 direction so there was discretion for the local health
11 boards as to how they were going to implement this
12 framework; is that correct?
13 A. That's correct, they had the opportunity to implement
14 this at a local level and these issues emerged from
15 a range of discussions with senior leaders in the NHS in
16 Wales, medical directors, about the types of actions
17 that would genuinely help them to prepare. So, rather
18 than just decide these nationally, these really emerged
19 over the course of the previous few days and in fact
20 were set out in some correspondence that we received
21 collectively from chief executives and also from medical
22 directors in Wales.
23 Q. After this framework of actions was issued on 13 March,
24 which effectively were suspending elective treatment,
25 can you help us, was there any guidance or instruction

1 from the Welsh Government about restarting elective
2 surgeries? And if so, when was that made?
3 A. So that happened later as we had come through the first
4 wave and had seen the peak and were starting to see the
5 opportunity to focus on other activities in the NHS.
6 We formally set these out in terms of requests
7 within quarterly frameworks, quarterly operating
8 frameworks that we used. And that's where we asked,
9 although it was done in a cautious manner, that there
10 were opportunities to start to recover some of our
11 activities.
12 In the first wave, in practical terms, our
13 planning horizon was having to work two or three weeks
14 ahead only, so the introduction of those quarterly
15 frameworks were really important to give that wider
16 guidance to the system and track it alongside the
17 concerns and worries of the virus as well. I should
18 explain that these operating frameworks were usually
19 discharged over a 3-year period, so this was quite
20 a change in our outlook for planning.
21 Q. If we can focus, please, on elective care in Wales and
22 when that was resumed.
23 The Inquiry has heard from two experts in
24 orthopaedic surgery, Professor Metcalfe and
25 Ms Chloe Scott, and I think a transcript of their

1 evidence has been provided to you. But they have
2 explained that multiple figures showed that the delivery
3 of restoration of elective care in Wales was
4 significantly delayed compared to that in England.
5 And Professor Metcalfe told the Inquiry that
6 meetings were first held about recovery of elective
7 orthopaedic care in Wales in 2021 and the first guidance
8 document was released in 2022. He made some criticisms
9 of the guidance document, saying that it's more vague
10 than the NHS England guidance and it's not linked to any
11 financial incentives for local health boards and, as
12 a result, treatment delays in Wales, in the words of
13 Professor Metcalfe, were absolutely huge.
14 Do you think that the Welsh Government should have
15 planned to recover elective care sooner in the pandemic
16 and taken steps to incentivise local health boards to
17 restore those local services?
18 A. Looking back now, where we are, I think we should have
19 done that earlier than we did. We did give permission
20 for the instigation of routine activity, including in
21 our first operating framework in May 2020, but that was
22 absolutely in recognition of the environment we were in
23 at the time. They were operational matters for health
24 boards to take forward. Whilst the orthopaedic summit
25 took place in 2021, other guidance had been given in

1 those operating frameworks for actually taking the
2 opportunity to restore guidance as well.
3 Q. In terms of practical steps that could be taken, can
4 I ask you this. The Inquiry has heard a recommendation
5 from those two orthopaedic care experts, and also in
6 relation to cancer care, colorectal cancer care, about
7 the use of elective hubs which would provide elective
8 surgeries on a separate site, away from urgent and
9 emergency care. Is that a recommendation that could
10 practically be implemented in Wales or are there
11 barriers to doing that?
12 A. Yes, that's a recommendation that can be implemented and
13 we did have set up within individual hospital sites as
14 well. There is a need for an understanding of the way
15 in which that would mean that services would be changing
16 across different areas of Wales. And when we are
17 normally working through these sorts of choices, there
18 are consultation processes, for example, not least with
19 communities, about understanding those change of
20 services. So it's just about recognising that there are
21 consultation and engagement mechanisms that we need to
22 do. But obviously within a pandemic there are different
23 ways in which you can respond to that in -- more in
24 an emergency mode.
25 Q. All right, thank you.

1 Perhaps we can move on now to following on from
2 the framework of actions which was published on
3 13 March. As well as expediting discharge, I think the
4 Welsh Government also produced some guidance on
5 admission to secondary care and published, on
6 23 March 2020, the Covid-19 primary and community care
7 guideline, and can we look very briefly at this, please.
8 It's INQ000226967. Thank you.
9 On page 7, please, there is a flow chart. This is
10 for primary care practitioners to go through this flow
11 chart as to whether to admit a patient, and there are
12 a series of questions there:
13 "Does your patient meet criteria for respiratory
14 distress?
15 "Does [the] patient have an advance future care
16 plan that applies in this case?
17 "Is the patient likely to benefit from ICU
18 escalation?"
19 "Yes", they're admitted to acute hospital; "No",
20 discuss admission with the front door clinician. And
21 there's an asterisk at "ICU escalation", and it says:
22 "Evidence shows that the following groups do not
23 respond well to ICU escalation:
24 "Clinical Frailty Score of 5 or above ..."
25 And if we can have a look quickly, please, at,

1 I think, page 16, it shows the Clinical Frailty Scale
2 there. 5 is "Mildly Frail".
3 Is it right that the purpose of the Welsh
4 Government in publishing this guidance and this flow
5 chart was to try to minimise the number of Covid
6 patients being admitted to hospital by general
7 practitioners?
8 A. It was to try to support the overall preparation but
9 also to try to push patients to the right level of
10 service that needed to be available. And this guidance
11 had been developed by our primary and community response
12 group, which included a wide variety of representatives
13 from all of our health organisations in Wales and was
14 led by clinical leaders as well.
15 Q. Thank you.
16 So this guidance was published on 23 March 2020,
17 and a little over two weeks later, on 8 April, it was
18 updated, according to your witness statement, to include
19 guidance that the Clinical Frailty Scale should not be
20 used in younger people, people with stable long-term
21 disabilities such as cerebral palsy, learning
22 difficulties or autism.
23 Now, the inquiry has heard from Dr Paul Chrisp of
24 NICE that the guidelines for critical care for Covid
25 patients that had been published on 20 March 2020 were

1 amended on 25 March to make that amendment about the
2 Clinical Frailty Scale not being appropriate for younger
3 patients with long-term conditions, as I've just set
4 out. Can you explain why it is that, after those
5 amendments were made to the NICE guidelines to clarify
6 that it was not appropriate to apply the Clinical
7 Frailty Scale to younger people -- why it took until
8 8 April for the Welsh Government to make similar
9 amendments to this admission criteria?
10 A. I can't respond to why that delay would have been there.
11 I would just be speculating but I would have thought
12 that the planning and response group could have been
13 taking a look at it again. But I won't be able to
14 respond to the specific question, I'm sorry.
15 Q. All right. Perhaps we can move on to increasing
16 capacity in terms of the medical equipment and supplies
17 that were going to be needed by the NHS in Wales.
18 And I think there were some concerns initially in
19 relation to items that were going to have to be sourced
20 on a four-nations basis.
21 And can we have a look, please, at INQ000479929.
22 This is an email from you, on 27 March, to
23 Vaughan Gething, who was then the Minister for Health
24 and Social Services, and this is raising issues about
25 supply arrangements for the UK, and we can see some of

1 the concerns that you had at this point of time.
2 So, you set out that there are some concerns
3 because of the way that testing and testing kits were
4 being supplied to Wales that you were concerned that
5 there may be some similar supply arrangement problems
6 with Wales not getting equitable access to either tests
7 or PPE or ventilators.
8 And can we see there point 3:
9 "Speaking to other devolved governments the
10 supply process is feeling that we are excluded from
11 the UK/NHSE arrangements, we are not sighted on the
12 workstreams at any level of detail and [this is] ...
13 affecting our ability to plan."
14 The, going on, it says:
15 "There is an emerging discussion about how
16 supplies -- whether ventilators, PPE or others -- will
17 start to be distributed to an assessment of need
18 rather than equity. The concern for this is that in
19 planning terms this will create concerns for Wales
20 about resilience and business continuity ..."
21 Your concerns seemed to be at that point that
22 effectively if the wave hit England first, their need
23 would be greater and all those finite resources would
24 have been used up by the time Wales needed to draw upon
25 them. Would that summarise what your concerns were at

1 that point?
2 **A.** Yes, they were genuine concerns and it was a very
3 fast-moving picture, but, yes, there were early signs of
4 planning for England having an impact on some of our
5 supply lines in Wales and we were just looking to make
6 sure that didn't happen in practice.
7 **Q.** Can I ask, did that happen in practice? Did those
8 concerns materialise?
9 **A.** It didn't happen in practice. I was really pleased with
10 the way in which colleagues responded. I think there
11 was possibly some clumsiness on some of the instructions
12 provided, so, for example, when liaising on areas such
13 as PPE, NHS England was being used as the criteria
14 rather than the NHS more generally and this is why
15 affected colleagues in Scotland and Northern Ireland as
16 well. But when able to escalate and talk to our
17 colleagues through our structures, at the times I did
18 that personally myself there was always a
19 very appropriate response and we were able to ensure
20 that that settled down.
21 But at this time we were seeing very significant
22 pressures in London for example. They were a few weeks
23 ahead of the first wave than the Welsh position and you
24 could just see how there was the potential for resources
25 to be drawn to those starting points for the virus in

1 the United Kingdom.
2 **Q.** All right. So looking then at ventilators, I think
3 you've set out in your witness statement that at the
4 start of the pandemic NHS Wales had 415 invasive
5 ventilation machines, 207 non-invasive ventilation
6 machines, and in 2020, 1,238 further ventilators were
7 procured by NHS Wales and also through UK arrangements
8 with the Department of Health and Social Care. At that
9 point when additional ventilators were in the process of
10 being procured or supplied, were any steps taken by the
11 Welsh Government to ascertain whether there would be
12 sufficient numbers of staff trained to operate those
13 additional ventilators?
14 **A.** In the first wave we were working through where it was
15 really important to make sure that we had the physical
16 capacity and then we had the equipment capacity. The
17 workforce plans were always being progressed and working
18 through. Just because we were planning at that point
19 for 1500 ventilators did not mean, of course, that there
20 would be 1500 -- sorry, staff available to support those
21 1500 ventilators. That will be something that we would
22 have to continue to progress, introduce the training and
23 introduce the skills. But we were always starting with
24 making sure that the physical requirements were in place
25 first.

1 **Q.** And did the Welsh Government take any steps to ensure
2 that there were enough trained staff to operate that
3 additional number of ventilators?
4 **A.** Not to that number at the outset but we were introducing
5 additional training, health boards had produced plans,
6 they were re-deploying staff, there was both local
7 training available, we were also escalating training
8 through the Critical Care Network, as well, I was making
9 sure that we were able to grow the number of staff who
10 were available but we were, at that point, well short of
11 any ability to manage 1500 ventilators if that situation
12 had happened in practice.
13 **Q.** All right, thank you. Now, plainly an increased use of
14 ventilators in hospital is going to require an oxygen
15 supply, sufficient oxygen supply, and I think it's right
16 that Welsh Government worked with NHS Wales and the
17 British Oxygen Company and the Royal Engineers to try
18 and expand existing oxygen capacity in the NHS estate.
19 And by June 2020 I think the Royal Engineers produced
20 a report which indicated that a 75% increase in oxygen
21 provision had been achieved. Was that sufficient to
22 meet the likely or the projected increase in demand for
23 oxygen?
24 **A.** If we were still moving to some of the modelling levels
25 which could still be at extreme, that level still would

1 not have allowed to us achieve it, but at the time
2 in June it was felt to be an appropriate recovery of the
3 oxygen facilities and we'd had some physical
4 developments in our estates as well, so we'd been able
5 to access oxygen for field hospital facilities where
6 that was needed and necessary. But if we had continued
7 to see the modelled position right through 2020 and into
8 2021, that would have continued to stretch our oxygen
9 capacity. Having said that, we were in liaison with
10 British Oxygen, we had clear recommendations, and we had
11 a group that was working that through with the local
12 health boards in Wales, and very regularly as well, so
13 we were always looking to progress that position.
14 Q. Now, can we move on, please. You touched there on field
15 hospitals. Can we look at field hospital provision in
16 Wales and the role of the Welsh Government in relation
17 to field hospitals.
18 I think it's right that the Welsh Government
19 provided funding for field hospitals and you've set out
20 in your witness statement that initially £166 million
21 was allocated to local health boards for field
22 hospitals. In 2020 to 2021 capital funding of
23 50 million was provided for field hospitals, in addition
24 to £10 million for the early opening of the Grange
25 hospital in Aneurin Bevan University Health Board.

1 £83 million was also spent on works across the estate,
2 some of which would have been spent on field hospitals.
3 So having allocated £166 million initially, can
4 you assist us with the total, the final Welsh Government
5 spend on field hospitals during the pandemic?
6 I can take you to paragraph 521 of your witness
7 statement if you like, which contains those figures, but
8 there aren't any other figures that have been provided.
9 Was that the final spend?
10 A. The formal cost -- yes, that was the final spend. I
11 mean, you're right that in respect of some of the
12 enabling estates work we were unable to set out the
13 specifics that were for field hospitals themselves so
14 the revenue costs as set out in that table were for
15 136 million but there were those additional capital
16 costs that we used as well.
17 Q. In terms of the number of patients admitted to field
18 hospitals during the pandemic, if we can go to page --
19 page 206, please, of your witness statement,
20 paragraph 514. You say that:
21 "In terms of numerical data of how many patients
22 were admitted to field hospitals for the relevant
23 period, the Welsh Government did not request this data
24 from the health boards as distinct from the admission
25 data."

1 That's the information we saw before about how
2 many bed were occupied, and so on.
3 Why did the Welsh Government not request data from
4 the local health boards about how many of the beds that
5 had been created in field hospitals had been utilised?
6 A. Within the sitrep reports, the category you were showing
7 earlier was allowing to us report on patients who were
8 outside of the normal hospital facilities, so we were
9 able to track the data very generally in there but it
10 was very minimal data because of the change and the
11 mitigating factors, the lockdown that occurred, we ended
12 up not needing to use the field hospitals as intended
13 of course. So there was a real change on it. But it
14 was set up within the sitrep report.
15 In respect of an understanding of how the local
16 health boards were using it, we did undertake reviews at
17 various points drawing in that experience and there was
18 a group available in Wales that was also tracking it as
19 well. But I think it would have been the sitrep data
20 field that would have allowed to us understanding it,
21 but there were very minimal numbers in there, as I was
22 saying, because we simply didn't use the field hospitals
23 as intended. They were a contingency preparation and
24 fortunately they did not need to be used in the way that
25 was intended.

1 Q. Can we look at some concerns that were brought to your
2 attention by some of the local health boards about the
3 resources that were going into field hospitals.
4 Can we see, please, INQ000474458.
5 This is an email from a local health board,
6 Cardiff and Vale local health board to the deputy Chief
7 Medical Officer. He says, if we can go to page 2,
8 please:
9 "I feel I need to send this email just to relate
10 what I see on the ground in Cardiff at least. I don't
11 have access to the [NHS Wales Information Service]
12 data on capacity elsewhere."
13 So the local health boards didn't have
14 information, is that right, about what was going on in
15 other local health boards or nationally across Wales,
16 they didn't have access to that data?
17 A. I would assume that they would have had access to the
18 data. We were always sharing it and discussing it in
19 the meetings that were happening at that time, but from
20 a sitrep perspective their focus would have been on the
21 submission of the local data.
22 Q. But it seems that the writer of this email is saying
23 that he doesn't have access to information about what's
24 going on in terms of other local health boards and their
25 capacity. But he goes on to talk about what's happening

1 within his health board. And he says:
2 "I write this because I am concerned about the
3 huge amount of resources going into dragons heart. My
4 prediction is that this will be an enormous white
5 elephant. I fully understand that [Welsh Government]
6 need to prepare for worst case scenarios, but
7 I question whether this is necessary given what is
8 happening on the ground."
9 And he says that there is huge capacity in the
10 system, at least in relation to that health board.
11 Were you aware of those kind of concerns? Did the
12 deputy Chief Medical Officer speak to you about any of
13 this in terms of the amount of resources that were being
14 diverted from local hospitals into field hospitals?
15 **A.** I can't remember if the deputy Chief Medical Officer
16 spoke to me directly on that day. I would typically
17 expect it because we were all with each other on a daily
18 basis and we were having these very open conversations.
19 The context at this time, of course, was that we had
20 built up these plans on the modelling and had been
21 working on those through March. We were still very much
22 in the first wave at this stage. Even, I think it was
23 six days after this that the peak of critical care
24 capacity that we reached in the pandemic was hit.
25 But I do agree with Simon in his note here that we

1 were actually seeing a very big impact on our available
2 capacity from the steps that had been taken on 13 March
3 so I --
4 **Q.** Right.
5 **A.** -- at that point was doing press conferences, and I was
6 reporting on the available capacity for the NHS in
7 Wales.
8 **Q.** All right. If we can focus then on what was happening
9 in field hospitals, and I think it's right that the
10 model of care for field hospitals was to provide
11 step-down care rather than intensive care facilities; is
12 that correct?
13 **A.** That's -- yes, that's the way the model worked in Wales,
14 that's correct.
15 **Q.** All right. So this was for patients who no longer
16 needed acute care but weren't well enough to go home; is
17 that right?
18 **A.** Yes, that's correct.
19 **Q.** And also to provide palliative care for patients with
20 a ceiling of treatment; is that correct?
21 **A.** That's correct.
22 **Q.** So can I ask you this. Given that the projections from
23 4 April were for 900 intensive care beds or critical
24 care beds and by that date we know that 356 beds had
25 been created with surge capacity within hospitals,

1 although they may not have been staffed at that point,
2 it was looking at that point as though Wales was not
3 going to be able to create 900 additional critical care
4 beds. In that case, why is it that no critical care
5 beds were to be created in field hospitals?
6 **A.** It was the clinical model that was determined for Wales.
7 It reflected the way in which the health boards wanted
8 to use their local capacity. What they were looking to
9 do was to make sure that they were able to expand their
10 critical care capacity on their individual acute
11 hospital sites and that they would be able to decant or
12 displace other patients into those other peripheral beds
13 which may at a moment have become the use of the field
14 hospitals as well, so it was an attempt.
15 Secondly, from a geographical perspective, and
16 just a reflection of our rurality, to some extent, we
17 needed to have a distribution of those beds that was
18 available across Wales and that's why that model was
19 used as a very local model as well, but it was to expand
20 the capacity on the acute hospital sites for critical
21 care and then to manoeuvre other beds into other areas.
22 **Q.** All right. Were the palliative beds for patients with
23 a ceiling of treatment, were those beds for patients who
24 could not be admitted to intensive care in the event
25 that full capacity had been reached? Was that the

1 thinking at that time? We're not going to be able to
2 create as many intensive care beds as the projected --
3 as the modelling is telling us we're going to need,
4 we're not going to be able to create 900 beds, we're
5 going to have to have some sort of palliative care
6 facility for people who, if intensive care is full,
7 they're going to have to go to a field hospital for
8 palliative care?
9 **A.** I don't directly recall that being the intention because
10 it was intended to bring patients who had gone through
11 their experience in the hospital and were to move to
12 another facility. It was possible that it could provide
13 some of that support if necessary. It would really just
14 be a question of the pressures that we were experiencing
15 and having the flexibility to use our capacity for those
16 different purposes.
17 **Q.** All right. So if we can move on past the first wave
18 then and the way that field hospitals were used there.
19 It appears from a briefing provided to the minister on
20 26 November that only two field hospitals were used
21 during the first wave and 46 and 34 patients were
22 admitted respectively. Where was that information
23 coming from if Welsh Government weren't collecting data
24 on the use of field hospitals?
25 **A.** We had information in that sitrep line which talked

1 about other hospitals but also the teams were just
2 always in contact with the individual health boards and
3 with clinical teams in Wales. That's just the way we
4 work on a normal basis and we would have been using
5 those relationships to describe that as well. There was
6 also a group in place that was overseeing and supporting
7 field hospital provision across Wales, partly
8 a peer support mechanism and Health and Social Services
9 Group officials were part of that group as well.
10 **Q.** So do you know whether any of the field hospitals were
11 utilised in the second wave, whether any patients were
12 admitted in the second wave?
13 **A.** There were. We were very fortunate that field hospitals
14 didn't need to be used. They were ultimately there as
15 a contingency based on the model. Having established
16 them we wanted to use as much as possible those that
17 were remaining for alternative purposes. So there were
18 field hospitals that were used for some patients when we
19 received the peak in the second wave, that was
20 in January 2021, and through that period of time, but
21 there were also alternative ways in which the field
22 hospitals started to be used including as vaccination
23 clinics.
24 **Q.** If we can focus on their uses as field hospitals for
25 now, because I think the minister on 26 November was

1 being informed that three of ten remaining field
2 hospitals were operational at that point in November?
3 **A.** Yes.
4 **Q.** You don't think they were used at all in the second
5 wave; is that right?
6 **A.** There were three field hospitals that were operational
7 but during the second wave which took us into 2021,
8 there were some of those small numbers of field
9 hospitals that were used and they were available.
10 Again, as we went into the second wave they were
11 a contingency preparation for us to have capacity that
12 we could expand into, so they were still discharging
13 their original role and intention, but we had reduced
14 the number of field hospitals from 19 to 10 by the time
15 we got to November 2020.
16 **Q.** All right. I think the three field hospitals that were
17 operational at that point were Deeside in
18 Betsi Cadwaladr University Health Board, Seren in
19 Cwm Taf, and the Grange University Hospital which wasn't
20 technically a field hospital. And I think you've been
21 provided with a Healthcare Inspectorate Wales report
22 dated 19 March 2021 into concerns about quality of care
23 provided at the Deeside field hospital, so that appears
24 that that was being used in the second wave; would that
25 be correct?

1 **A.** Yes, that was one of the field hospitals that was in
2 operational use at that time, yes.
3 **Q.** And that report identified a number of failings
4 including problems with IPC measures at that field
5 hospital, a lack of individualised end-of-life care
6 planning and failure to use the end-of-life care
7 pathway.
8 Can I ask you this, had you been made aware of
9 those concerns about the quality of care being provided
10 in that field hospital prior to the Healthcare
11 Inspectorate Wales report?
12 **A.** I hadn't been advised of it before it, but I was
13 obviously aware when Health Inspectorate Wales did their
14 visit.
15 **Q.** So those concerns hadn't come through, through any of
16 the groups that you've just mentioned that were set up
17 within the Health and Social Services Group, that
18 information wasn't filtering through?
19 **A.** It hadn't, nor had they come through the health board
20 itself, no.
21 **Q.** Did the Welsh Government have any way of monitoring the
22 quality of care provided at field hospitals?
23 **A.** We were in contact with all of the health boards on
24 their plans and proposals. We had our professional
25 networks in place. So nurse directors would be able to

1 speak with the Chief Nursing Officer and oversee those
2 arrangements. We weren't doing our own assurance
3 visits, we were very much leaving those legal and
4 operational visits to the health boards at the time and
5 the regulator's role, Health Inspectorate Wales, is one
6 of those ways in which we were able to get that more
7 independent voice and to allows us to understand that
8 from a national level as well as, of course, the direct
9 actions needed to be taken by the health board.
10 **Q.** Did the Welsh Government undertake any review of the
11 field hospital programme in order to evaluate what
12 worked and what didn't?
13 **A.** There were two points in particular where reviews were
14 undertaken. There was one in June 2020 which was
15 an early review of the way in which the facilities had
16 been established and the issues that had been faced. As
17 I said, there was a group available.
18 **Q.** What was the nature of that review, please? Was that
19 an Audit Wales review or what was the body?
20 **A.** It wasn't an Audit Wales review. That was actually done
21 by the Health and Social Services Group working with
22 a field hospital group in Wales to review it, and there
23 was a similar review done on a similar basis, I think
24 it was in March 2021, as well.
25 **Q.** So June 2020 and March 2021, but nothing at the end of

1 the programme?
2 A. You would have to speak to Judith about how she picked
3 up issues after the end of the programme, after the
4 pandemic was finished, after October 2021, but I don't
5 recall anything. There were learning reports that were
6 produced, I know, because of the interest in field
7 hospitals and how they had been established and how
8 staff worked together but they weren't directly
9 commissioned by the Welsh Government.
10 Q. Perhaps we can move on and look at the use of private
11 hospitals for NHS care during the pandemic. I think,
12 again, this was funded by the Welsh Government and
13 £30 million of funding was agreed on 25 March 2020 for
14 the commissioning of additional capacity from the
15 independent sector. Is it correct that that total
16 capacity was 152 beds, some of which were day case beds
17 in six inpatient hospitals across Wales? I think it's
18 right that there weren't any intensive care beds
19 provided in private hospitals; is that right?
20 A. Yes, that's correct, and your point on critical care
21 capacity is correct as well.
22 Q. Did the Welsh Government collect data on how much
23 activity was performed under those contracts that it had
24 funded?
25 A. The contracts were overseen by the Welsh Health

1 Specialised Services Committee that was acting on behalf
2 of the local health boards.
3 Q. Did you collect data on how much activity was performed?
4 A. The tracking and monitoring was done through that
5 mechanism. It wasn't necessarily done through Welsh
6 Government at that time. It was an operational matter
7 for the health organisations.
8 Q. Did you have data -- do you know how many operations or
9 other activities, outpatient appointments were delivered
10 through independent providers for NHS patients?
11 A. We had reports from the Welsh Health Specialised
12 Services Committee but they were not part of our daily
13 sitrep data.
14 Q. No, I didn't ask whether they were part of your daily --
15 perhaps we can go to page 218 of your witness statement
16 paragraph 545.
17 If we can get up page 218, please, thank you.
18 You say:
19 "Weekly sitreps on activity were developed ... on
20 behalf of NHS organisations for monitoring purposes and
21 to ensure maximum usage of the capacity available. This
22 information was not produced by or held by the Welsh
23 Government as it was not a party to the contract
24 arrangements."
25 Does that mean that you didn't have that

1 information?
2 A. It means that we were -- we would receive the
3 information when officials were liaising with the Welsh
4 health services committee, but we were not formally part
5 of the contract review and monitoring information so we
6 could have it available, we could be provided with it,
7 but we weren't formally monitoring the contracts.
8 Q. Do you know how much activity was performed under those
9 contracts when the contracts ended? Would you be able
10 to give us --
11 A. I can't recall where in my statement I set out those
12 numbers but we had information available that was
13 provided to us by the Welsh Health Specialised Services
14 Committee that would tell us what those numbers were,
15 and we were reporting it internally in order to have
16 an understanding from -- various occasions within our
17 Health and Social Services Group arrangements and also
18 with the NHS leadership board as well.
19 Q. I don't think there is anywhere in your witness
20 statement where you set out those figures, but they are
21 available to the Welsh Government, are they?
22 A. They will -- I'm happy to report back on those figures
23 that we have available.
24 Q. All right.
25 Can we turn, please, to some PPE issues in

1 healthcare settings and in hospitals. You have
2 explained in your witness statement that there was a PPE
3 pandemic influenza stockpile that was held in Wales, and
4 at the beginning of the pandemic that was utilised until
5 the pandemic arrangements were completed with the
6 Department of Health and Social Care and so on.
7 In your view, were the existing pandemic influenza
8 stockpiles of FFP3 masks at the start of the pandemic --
9 were they adequate for the Welsh Government needs?
10 A. I think, based on our experience, the supply set aside
11 was inadequate for what we were seeing in respect of the
12 Coronavirus experience. So whilst they had been
13 established for a pandemic flu, we were receiving
14 something different. Nevertheless, the availability of
15 the stocks alongside the central stores and of course
16 local health boards' own supplies meant that we were at
17 least able to flexibly use PPE stocks available across
18 Wales until we had been able to restore some more
19 effective supplies.
20 Q. And you set out that in Wales there was a dual pronged
21 approach to PPE procurement: there was the four nations
22 basis, where the UK acted as the lead purchaser and led
23 on behalf of the four nations, and then there was
24 a Wales-only basis, where I think it was the NHS shared
25 services partnership in Wales were operating a separate

1 procurement system; is that correct?
2 A. That is correct, although we shifted more towards the
3 use of the Wales approach through our experience in
4 those early weeks in particular.
5 Q. Can I ask how effective it was to have those two systems
6 operating in parallel and whether there were any
7 difficulties with that? You said that you ended up
8 moving more towards the Welsh system.
9 A. We were finding difficulties with the supply system
10 being put in place at UK government level. Of course,
11 for NHS England, because the procurement that was taking
12 place was often buying up in bulk supply lines that
13 meant that the NHS in Wales was sometimes not able to
14 access its normal supply routes as well.
15 I think one useful example I set out in my
16 statement is of a company based in Wales that, whilst it
17 always provided some residual stock to England, they
18 suddenly had an approach which would have taken away all
19 of the usual stock that we would have been drawing into
20 our central stores in Wales. So there were very
21 practical experiences.
22 There were, however, some good examples where we
23 were able to access some of the international supply
24 lines through UK colleagues and working with the NHS in
25 England as well. But ultimately we decided that the

1 best way of securing the national supply for Wales was
2 reverting more to working through our Welsh national
3 shared services arrangements in place, and we were very
4 fortunate to have established a national organisation
5 with this very specific role.
6 Q. Can we look briefly at some of the concerns that were
7 coming from the front line with healthcare workers who
8 were using PPE and their concerns about the stocks and
9 availability of PPE in Wales.
10 I think you've been provided with the witness
11 statement of Adam Morgan, from the Wales Trades Union
12 Congress, and he sets out in his witness statement that,
13 due to concerns about very low stocks of PPE in Wales,
14 measures were taken in healthcare settings including
15 staff being told to be sparing with PPE, to reuse PPE,
16 to purchase their own items that they could use as PPE,
17 like using bin bags as aprons, and staff being
18 encouraged to share single-use PPE.
19 Is it correct that those concerns were brought to
20 the attention of the Welsh Government in April of 2020?
21 A. Yes, that was correct. We had also had other views
22 reflected on concerns on PPE. I remember the BMA, for
23 example, who spoke to me as well as wrote to me at the
24 time, in March, so those frontline experiences and
25 concerns were really important and to respond to it, but

1 also to be able to communicate about the availability of
2 PPE as well.
3 Q. Can I ask you then what steps the Welsh Government took
4 in relation -- in terms of addressing those concerns
5 that were brought to their attention?
6 A. Well, when we were looking back at this in early March,
7 which is when I recall having the concerns raised, it
8 was one of the reasons to start using the countermeasure
9 store, the pandemic flu stock. And that required
10 ministerial authorisation. And we were able to get
11 those out across the NHS and Wales, not just to hospital
12 sites and distribution centres but actually out to
13 primary care and to GP surgeries. So it was really
14 important that we showed that there were other stocks
15 available beyond the local stores.
16 We had a PPE cell established and were working
17 through choices that we needed to make. We were trying
18 to work on the supply chains that were available. But
19 I think one of the most significant things was trying to
20 give confidence about the availability of the supplies
21 and the stocks that were available both nationally but
22 of course more on a local basis as well. I thought
23 there was some very good practice that was introduced by
24 health boards that we adopted for all, which was
25 communicating to their staff actually about the

1 supplies, which would not be done on a normal basis but
2 were describing the number of days' supply that were
3 available. And we also translated that at a national
4 level, to be describing that through both ministerial
5 statements but actually being asked those questions in
6 press conferences, for example, where we were very open
7 about the supplies that were available.
8 So our role was to secure those national stocks,
9 and we did so, but we had to share in a very salutary
10 way, at a national level and very publicly, but we were
11 down on some supply areas, even to a couple of days of
12 supplies. I think, gowns, at one point we were down to
13 only two days of supply left in our central stores
14 across Wales, and then they were replenished within the
15 following 24 hours.
16 Q. Can we leave PPE there for now, please, and move on to
17 steps to test patients and healthcare workers in
18 hospital settings. And if we can look at first of all
19 at patient testing. I think on 7 April the Welsh
20 Government issued Covid-19 hospital discharge
21 requirements and, although that was later updated,
22 I think the initial guidance did not require the patient
23 to be tested before discharging from hospital into
24 a residential placement. I think it was on 24 April
25 that that requirement came into force; is that correct?

1 **A.** Yes, the guidance on 9 April reflected the evidence at
2 that time, and yes it was updated on 24 April to make
3 those changes to require a test before a discharge to
4 a care home.
5 **Q.** Do you know why it took until 24 April to make those
6 changes?
7 **A.** I would -- I can't recall that it explains that in my
8 statement. As I recall, we were always taking the very
9 rapidly changing evidence at the time. Groups were
10 working on that. We were trying to issue it into the
11 NHS out to our staff and to our hospital sites to make
12 sure that they were aware of it, but I can't recall why
13 there was a particular delay for it at that time,
14 because our practice tended to be that we were trying to
15 update the guidance as soon as we were aware of the
16 changes as well. But I can't recall the area in my
17 statement that explains that.
18 **Q.** Obviously the concerns with or the necessity to test
19 patients before they were discharged into a residential
20 setting was clearly the concern that that patient might
21 be infectious and then would go on to infect the people
22 in that residential setting.
23 Can I ask you this, community hospitals are not
24 mentioned in the discharge guidance or the letter
25 setting out those changes of 24 April. Was there ever

1 a discharge policy or guidance which required testing of
2 hospital patients before they were discharged from
3 an acute hospital into a community hospital?
4 **A.** I can't recall that, because they would be within the
5 local health board facilities so patients typically
6 would move across areas because that's the way in which
7 we function: somebody comes into an A&E department, they
8 move to a ward, they move to the best location, safely
9 of course, for their care.
10 I can check that for you but I don't recall that
11 there was different guidance. It was just part of the
12 normal way of the NHS discharge and its arrangements.
13 **Q.** So that would mean, wouldn't it, that patients wouldn't
14 be tested before they were moved from an acute hospital
15 into a community hospital? Wasn't there the same risk
16 of them causing an outbreak within the community
17 hospital?
18 **A.** There's possibly the same risk. I would just have to go
19 and check what those arrangements are but I just can't
20 answer the specific question, I'm afraid, without
21 checking that with other colleagues. And I don't recall
22 it being in my statement either.
23 **Q.** Wales was, we have heard, behind England in relation to
24 both the expansion of testing for asymptomatic
25 healthcare workers and NHS patients, and, again, on the

1 announcement in December of 2020 of routine testing of
2 asymptomatic healthcare workers. What was the reason
3 for the delays in Wales in relation to those testing
4 policies?
5 **A.** The testing policies that were set out were always set
6 in context of the available testing capacity that we
7 had. So as we went through 2020, we obviously saw some
8 very significant changes in the numbers of tests that
9 were available that could be used for all of the
10 different purposes, from diagnosis to surveillance
11 through to those protective measures with our staff as
12 well.
13 If you look at the outset of the pandemic, back
14 in March and April we only had between 2,000 and
15 8,000 tests available on a weekly basis. By the time we
16 got to December, those numbers of PCR tests that were
17 available were as high as 130,000, for example, in
18 a week. So you're suddenly at a very different position
19 in terms of how you can use things.
20 **Q.** Yes, if I can stop you there, Dr Goodall, I wasn't
21 asking why it took that long to be able to have a policy
22 of routine testing of asymptomatic healthcare workers,
23 I'm asking why there was a delay in Wales in comparison
24 to when those policies were rolled out in England. Was
25 there a specific reason why it took six weeks?

1 **A.** There was a reason at that time. So when England rolled
2 out their asymptomatic testing, they were using LAMP
3 technology where they had laboratory systems in place to
4 support them. From our perspective in Wales, and having
5 had the advice that we wanted to revert to the
6 asymptomatic side, if we had gone down the use of the
7 same LAMP technology and accessed that through the
8 national laboratories, we would have had to have set up
9 and trained laboratory staff with those particular
10 skills, and that would have had to have been dedicated,
11 so that would have taken time.
12 The game changer for us at that time though was
13 the alternative opportunity to use lateral flow devices.
14 They were still subject to some scientific assessment
15 but we were able, with that clarity, to confirm the
16 start of the testing regime on 4 December 2020, and then
17 we were able to start the roll-out on 14 December.
18 **MS NIELD:** All right. Thank you very much.
19 My Lady, I don't know if that's an opportune
20 moment.
21 **LADY HALLETT:** Of course, yes.
22 11.32.
23 **(11.17 am)**
24 **(A short break)**
25 **(11.32 am)**

1 **LADY HALLETT:** Ms Nield.
2 **MS NIELD:** Dr Goodall, if we can move on to a new topic,
3 please: the shielding programme in Wales.
4 The Inquiry understand that the shielding
5 programme was led by the Chief Medical Officer, and my
6 questions to you are based on your oversight role or
7 your role in relation to those logistical issues which
8 arose rather than anything on the clinical side of that
9 programme.
10 You've set out within your witness statement that
11 there were some problems with 13,000 of the
12 initial 91,000 shielding letters going to the wrong
13 address, being sent out to an old address, a previous
14 address. I'd like to ask about some more issues with
15 letters going to the wrong people, if I may, and
16 particularly about shielding letters that were sent to
17 people with Down's syndrome.
18 I think the shielding patient list was updated to
19 include adults with Down's syndrome, and I think
20 those -- that decision was made by the four nations'
21 chief medical officers on 30 September 2020. It appears
22 that the Easy Read letter for people in Wales with
23 Down's syndrome was drafted in November of 2020.
24 I don't know that we need to go to that letter but it's
25 in draft form.

1 Can you help us with why it took at least a month
2 to send that letter out to those adults in Wales?
3 **A.** I don't recall why there was a specific delay. We
4 wanted to update the letters in the light of the
5 clinical evidence and the agreements amongst the chief
6 medical officers. I can't recall me explaining that in
7 my statement and I don't know if there were any specific
8 reasons why that wasn't issued. My own view would be
9 that it should have been issued when the chief medical
10 officer changes were made but I don't know why there was
11 a delay.
12 **Q.** Can we have a look at a letter that was sent to children
13 or under 18s with Down's syndrome.
14 That's INQ000469066.
15 This, again, is an Easy Read letter. It's dated
16 5 January 2021. And it explains that it's a correction
17 to a letter of advice that had previously been issued.
18 It doesn't explain when that letter was previously
19 issued. Do you know whether, when adults with
20 Down's syndrome were written to, to advise them to
21 shield, whether children or those under 18 with
22 Down's syndrome were written to on the same occasion?
23 **A.** I don't know that.
24 **Q.** All right. You maybe can't assist with that. But it
25 appears that, erroneously, children with Down's syndrome

1 should not have been added to the shielded patient list
2 but were written to and told that they were needing to
3 shield. It may be that you don't know how that mistake
4 occurred. Can you assist us with that?
5 **A.** The whole process of the shielding letters was a very
6 technical and complex process. We had never done
7 anything like this in Wales before, about the way in
8 which we were linking a wide variety of databases that
9 were available. There were so many technical processes
10 to go through. We were having guidance that was
11 changing. We were having to update it. Obviously there
12 were patients who were being diagnosed with conditions
13 that fitted within the shielding criteria that changed
14 from even the first issuing of those letters.
15 So I just would want to describe that kind of
16 context, is there would never have been any intention to
17 send an inappropriate letter or the wrong guidance but
18 it was often happening at pace and it was very
19 technically complex to keep on top of the changing
20 arrangements of patients during that period of time, and
21 I apologise if there is any impact of that, of course.
22 But I hope by correcting that in January we were at
23 least able to make sure that the guidance was clear in
24 terms of how shielding should be applied or not.
25 **Q.** But you can't assist us with how long it was after the

1 letters were sent out incorrectly to under 18s with
2 Down's syndrome that this correction was made?
3 **A.** I don't know. It would feel that there was a delay up
4 until this point reading the letter. What I can say is
5 when the original 13,000 letters had gone to previous
6 addresses, that was addressed very immediately and they
7 were sent out within a few days of that particular error
8 at that time. But I can't respond on this very specific
9 area, I'm afraid.
10 **Q.** Perhaps we can move on then and look at the use of --
11 the increased use of remote technology, briefly, in
12 healthcare settings. You set out in your statement that
13 the Welsh Government took a number of steps to encourage
14 greater use of remote technology in healthcare settings,
15 both in secondary care and in primary care, using the
16 Attend Anywhere platforms and through other means.
17 The Inquiry has heard that the increased use of
18 remote technology has the potential to risk exacerbating
19 inequalities for patients who may have struggled to
20 access healthcare through those remote means, and we've
21 heard about the "digitally excluded", that's the
22 terminology that's been used.
23 Can I ask you this, did the Welsh Government take
24 any steps to address that potential risk of digital
25 exclusion of some patients when they were encouraging

1 the greater use of remote technology in healthcare?
2 A. Yes, there were steps taken. We already had excellent
3 policies for the use of technology in Wales that
4 reflected on digital exclusion, and of course that would
5 mean that we were using that excellent guidance and
6 guidance throughout this process as well.
7 There is always a danger that when you are
8 changing the way in which you organise our services --
9 and this was done in an exceptional way, at the -- at
10 speed as well -- but you still need to retain,
11 of course, those other routes for patients as well. And
12 we wouldn't have assumed that there would have been
13 comprehensive coverage for these areas. But these were
14 at least a way in which we could, at volume, have
15 alternative ways in which patients could still be seen
16 within the system as well.
17 By the time, through the pandemic experience, we
18 were in 2021 we were able to make sure, for example,
19 that the digital strategy that was re-issued was able to
20 reflect on those areas and make sure that we were able
21 to understand that not everyone would be able to access
22 the digital technology that we were using as well.
23 But it was there for professionals to use and was
24 there, in line with a general offer that people would
25 have the right access to those services as well.

1 Q. A new topic, please. Can we look at staffing issues
2 within the NHS and, first of all, in terms of staff
3 availability, and the impact of staff absence for
4 illness and other reasons.
5 Your witness statement sets out that the Welsh
6 Government requested information on staff absence from
7 all NHS bodies from 20 April 2020. Was -- that was the
8 first time that that information had been requested
9 I think on a daily basis; is that right?
10 A. Yes, requested on a daily basis but we had certainly
11 been using operational information from health boards
12 before that time, and I personally recall using it in
13 some of my press conferences, for example, when I was
14 talking about the NHS experiences. But it was the first
15 time that we'd introduced it as a daily requirement,
16 yes.
17 Q. And is the importance of collecting staff absence rates
18 on a daily basis that that gives an idea about the
19 operational impact of that staff absence, so that
20 particular unit is down by this many staff, or this
21 percentage of staff, and that affects how many patients
22 can be seen, and so on and so forth? Would that be
23 correct?
24 A. Yes, that's absolutely the position and, you know, there
25 would be examples across Wales through that data where

1 we would be seeing potentially even individual
2 departments affected so that they were unable to carry
3 out their functions and, you know, it would be a very
4 salutary way in which you had this understanding of the
5 impact on our staff across Wales.
6 Q. So if that data was being presented as monthly absences,
7 for example, we're not able to see the, sort of,
8 day-to-day impact of those absences; is that right?
9 A. Yes, typically NHS Wales wouldn't have been looking at
10 it on a daily basis. It was an exceptional introduction
11 to track the experience of the pandemic.
12 Q. And you explain that from 9 August 2020, that workforce
13 absence data was collected once a week or fortnightly
14 depending on the Covid situation. Can I ask why that
15 changed at that point from daily collection, given the
16 information you've explained to us about the importance
17 of knowing the daily picture?
18 A. I think at that time, in the summer, we had seen
19 a reduction in the Covid prevalence levels. We had
20 hospitals across Wales reporting available capacity and
21 lower numbers of Covid patients. It was an adjustment
22 in respect of removing that requirement from the health
23 organisations, they had it themselves, and obviously
24 an opportunity to re-introduce it, which we did later,
25 of course, when we were going into subsequent waves and

1 seeing those pressures rise again. But it was a moment
2 where there was not the same level of pressure at that
3 precise point during August 2020.
4 Q. Can you help us with when daily data collection was
5 re-introduced?
6 A. I can't recall and I don't think it's set out in my
7 statement when that was re-introduced again, but
8 I recall using the sickness absence data very regularly
9 myself. I can check that, of course, further to today's
10 attendance.
11 Q. We've also heard about returning NHS staff who have
12 either retired or moved to work in different occupations
13 who were added to the temporary or emergency register to
14 assist with the workforce during the pandemic. Did the
15 Welsh Government obtain any data to identify how many of
16 these registrants were in fact deployed or offered roles
17 in the NHS in Wales?
18 A. We only had the overall position of those who had
19 returned. We didn't have any of the local information
20 in the manner in which they were deployed and there were
21 other staff, as well, that we were using in these
22 figures. We were also using students, for example,
23 within their educational placements who were also
24 supporting us, so it was a wide variety of staff coming
25 in through there. But we would be able to report the

1 aggregate position but not specifically where they were
2 being used. That would be more a matter for the local
3 health boards.
4 Q. What I'm seeking to ascertain is whether the Welsh
5 Government had any data on how many of the people who
6 had, effectively, volunteered to come back and work in
7 the NHS and had been added to the register, ready to be
8 deployed, how many of them were actually used? Because
9 we've heard there were some difficulties with people
10 ready and willing to return to work in the NHS and never
11 receiving a call that they had a place to go and work.
12 So did the Welsh Government keep any data on that
13 or, indeed, on the students that you've mentioned?
14 A. I don't recall on the use. We set up those
15 arrangements, we enabled it at a national level, we made
16 it available, but I would have to go and seek those
17 figures as well. I know Jean would have reflected on
18 some of those in her own evidence on the nursing side.
19 But unless you could take me to a section of my
20 statement, I don't recall that it's set out there in the
21 detail that you're asking me for today.
22 Q. No, I don't think that figure is -- does appear there.
23 So, Welsh Government did, I think, have absence
24 rate information from a TAC science evidence report
25 in February 2023, which you cite in your witness

1 statement at paragraphs 603 and 604, but if I can
2 summarise it in this way, that report from February 2023
3 indicated that the average number of sick days per
4 employee had remained consistent over the preceding
5 five years and that the leading reason for sickness
6 absence amongst NHS staff was anxiety and stress, and
7 that absence due to anxiety and stress had increased
8 year on year, so the total number of staff absent had
9 not increased but there was a greater weighting towards
10 stress and anxiety as the principal cause.
11 Can I ask this, was there any national monitoring
12 of staff mental health and well-being undertaken by the
13 Welsh Government during the pandemic?
14 A. There was monitoring and there were also actions that we
15 put in place and enhanced. So there was a national
16 scheme, for example, about support for health
17 professionals that was run by Cardiff University. We
18 ensured that that was available, it traditionally being
19 available for doctors but we expanded it to include
20 a wider range of NHS staff.
21 We were always working with the health boards to
22 understand things that could help. I have to say that
23 a lot of the mechanisms that were most supportive to
24 staff to allow them to reflect on their experiences were
25 overseen locally, whether they were through formal

1 occupational health arrangements or whether they were
2 just peer support mechanisms that were put in place.
3 But there were some things that absolutely we
4 could do at a national level and we have continued to,
5 obviously, monitor and support those areas. One of my
6 outstanding concerns, given the extended period of time
7 here, is that whilst we are through the pandemic
8 experiences we will still have staff who have
9 experiences that are affecting them right now and it's
10 really important to be able to keep up those support
11 mechanisms both nationally and on a local basis.
12 Q. You mention there that some of the effective forms of
13 support were provided by the local health boards. Can
14 I ask you this: did the Welsh Government undertake any
15 review or evaluation of staff well-being programmes or
16 staff support offers to identify what were the most
17 effective means of support?
18 A. I would need to check directly but I recall our
19 workforce group under our planning and response
20 structures were working on those areas. They were
21 helping us with some of the enhancements that we needed
22 to agree -- both ourselves and also with ministers as
23 well, but I'd have to check the specific detail.
24 Q. Thank you. Could we look, please, at the steps the
25 Welsh Government took in relation to creating a risk

1 assessment tool for NHS staff or, at least, initially
2 NHS staff.
3 Can we go, please, to INQ000282020.
4 This is a report of the workforce risk assessment
5 subgroup which is a subgroup of the First Minister's
6 black, Asian and minority ethnic Covid-19 advisory
7 group.
8 Can we go to page 23 because this sets out
9 a timeline of the development of the tool.
10 And so we can see that expert advisory group
11 meetings began on 29 April. On 1 May you, Dr Goodall,
12 endorsed the use of an existing risk assessment tool
13 that had been developed by Aneurin Bevan University
14 Health Board, so that was already in existence, is that
15 right, and it was going to be used across Wales or was
16 that going to be used as the basis for the all-Wales
17 risk assessment?
18 A. This was an important area because the correspondence
19 came in on 19 April, but even though we had commissioned
20 the group to do the work and wanted to do it apace we
21 just didn't want to have a delay and we were aware of
22 the work Aneurin Bevan Health Board had done. So just
23 in a very practical way, just wanted to make that
24 available, roll it out and give all of the health boards
25 and health organisations access to it, pending the

1 production of a template.
2 So I know that the group, of course, reflected on
3 that template that did exist but they also did their own
4 work to produce a much better and more refined version
5 as well.
6 **Q.** Right.
7 **A.** But it was more to ensure that there was no delay in
8 terms of the support that could be provided.
9 **Q.** So we can see on 5 May the risk assessment subgroup
10 first met and commenced its weekly meetings, and then on
11 27 May the workforce risk assessment tool was made
12 available as a pdf on the Welsh Government website for
13 immediate use across the NHS and social care.
14 Can you assist with why it was that the Welsh
15 Government tasked this particular group, the black and
16 minority ethnic subgroup with the development of the
17 workforce risk assessment tool?
18 **A.** There was an opportunity because of the correspondence
19 that had come in from Professor Singhal on 19 April. We
20 have close relationships with our clinical teams, with
21 our groups and with our organisations in Wales and
22 Professor Singhal had written to the First Minister.
23 The First Minister was very clear on this, that he
24 wanted the external support to be very visible. We were
25 able to put in the relevant NHS support, as you would

1 expect, and was very happy to be able to take up
2 Professor Singhal's offer to lead the work and we were
3 able to balance the NHS representation alongside, some
4 of the expertise we had in Welsh Government and beyond
5 it as well.
6 But it did form part of the wider arrangements
7 that were put in place for our black, Asian and minority
8 ethnic staff and people and other work that the First
9 Minister had commissioned as well, so I thought it was
10 useful to have that as a package.
11 **Q.** All right. Can we look briefly at the way that that
12 tool developed or to, perhaps, contrast the initial
13 tool, as first published on 27 May, with at the time of
14 this report, which was I think July or June of 2021.
15 So if we can have a look, please, at page 33.
16 Thank you.
17 And if we can see the steps are set out there,
18 that the first thing to do is to complete the risk
19 assessment, understand the risk and identify the right
20 actions for you.
21 And we can see, at the bottom, that pregnant women
22 may be particularly vulnerable and must not work in
23 direct patient-facing roles beyond 28 weeks. And it
24 says:
25 "Important note -- If you are of a Black, Asian,

1 Minority or Ethnic ... background and under 28 weeks
2 pregnant.
3 "New information ... indicates that they are at
4 considerably increased risk throughout that their
5 pregnancy and so should avoid face-to-face contact with
6 COVID-19 cases. This means no frontline work where
7 there is sustained community transmission."
8 And if we can see page 34, please, this gives the
9 scores for the risk assessment tool. And can we see
10 step 1, please. The box that says "confidential once
11 completed".
12 So here we see the risk factors are set out and
13 there if you're aged between 50-59, 1 point, 60-69,
14 2 points and over 69 doesn't appear on this initial
15 iteration. But "Ethnicity":
16 "Do you identify as one of the BAME or Mixed race
17 groups as set out in [a] link?"
18 There is 1 point there. And then we also see
19 there are 1 point for various comorbidities, obesity and
20 family history.
21 And can we come on, then, to look at what was then
22 the current version on page 37, please. We can see
23 that's 29 June 2021.
24 If we can go over the page to page 38, please.
25 Can we see at the bottom pregnancy, the advice has

1 changed now. It says:
2 "All pregnant women should undertake
3 an individual risk assessment. This is because
4 pregnant women may be particularly vulnerable ..."
5 So the advice for pregnant women has changed.
6 And if we can go on to page 39, please, and see
7 the scores that are attributed for different risk
8 factors. And if we can see the box in the lower half of
9 that page. The risk factors, there's now included
10 workers aged between 70-79 and they're ascribed 4 points
11 if they're in that age bracket.
12 So would you agree that failing to include that
13 age range in the initial risk assessment was quite
14 a significant omission?
15 **A.** Yes. I think clearly we knew that age was a factor on
16 Covid. Of course this was the work of the group and we
17 were very happy to take advice on the amendments that
18 needed to be made but, as I look at your comparison,
19 that would feel that was an omission, I agree.
20 **Q.** And we can see that on that page there's a point for
21 ethnicity still at that stage and still the same
22 comorbidities are set out, obesity and family history.
23 Do you know at what point it was that those changes were
24 made to include older members of the workforce?
25 **A.** I don't know. Those numbers would have been small

1 across Wales, over those age groups, but I don't recall
2 the precise date. But this work was done by an expert
3 clinical group with our clinicians across Wales, with
4 workforce support and they were left to develop it in
5 line with the guidance and the evidence, and I thought
6 they really did an excellent job pulling that together
7 and very quickly, given the circumstances as well, but
8 I don't recall precisely the date, I'm afraid.
9 **Q.** Can you tell us this, was it mandatory for the local
10 health boards to ensure all their staff or workers,
11 whether employed or outsourced, was it mandatory for
12 them to ensure that they undertook a risk assessment for
13 all staff?
14 **A.** It was not mandatory but this was issued to emphasise
15 the importance of it to make sure that people used it.
16 Our overall numbers showed us that not all staff were
17 subject to the review. We know that 71,000 staff of
18 around 100,000 NHS staff around Wales had the review
19 done. We know there were 74,000 across public services
20 that used it because this version, despite its health
21 context, was then used in other sectors as well as
22 a helpful way of understanding risk assessment in other
23 areas too.
24 **Q.** Did the Welsh Government do anything to monitor the
25 local health boards' compliance, did they do anything to

1 check how many staff were being assessed?
2 **A.** It was left very much as a local operational matter for
3 the health boards in line with their legal and statutory
4 responsibilities.
5 **Q.** All right. I think you've been provided with this
6 statement of the medical director of University Hospital
7 Wales. He sets out some concerns about the risk
8 assessment tools and particularly the lack of guidance
9 accompanying the risk assessment tool. He says it was
10 originally only available as a paper document and then
11 subsequently only on the ESR, which I think is the
12 electronic staff record, is that right, where it was not
13 easily found. Had you been made aware of any of those
14 issues with the accessibility of the risk assessment
15 tool for staff?
16 **A.** I was aware of some of the early problems because it was
17 being provided in a static way. We tried to, over time,
18 use the electronic staff record but we also wanted to
19 make sure if people just wanted to download a paper copy
20 and use it, that that was also appropriate as well, and
21 there were 49,000 copies that were actually downloaded
22 which we would assume were used as part of that more
23 practical approach as well.
24 **Q.** Thank you. So finally, lessons learned and
25 recommendations.

1 You've explained to us that you moved from your
2 role as Director General of the Health and Social
3 Services Group in November 2021 and I think your
4 successor in that role will be dealing with formal
5 lessons learned and exercises undertaken by the Welsh
6 Government, but I'd like to ask, if I may, for your
7 personal reflections on the challenges that arose for
8 the Welsh healthcare system in responding to the
9 pandemic and whether you can identify for the Inquiry
10 any areas of the pandemic response where you would seek
11 to do things differently in a future pandemic?
12 **A.** It's very difficult, even when giving evidence or the
13 range of statements that I've already done, to convey
14 how it was and how it felt at the time, with the way in
15 which this virus was developing at pace, the need to
16 turn the way in which we organised the NHS upside down
17 and even approaching areas like being asked to double
18 our capacity which was something that had never been
19 considered in any previous arrangements as well.
20 And if I could just say on the record, I just
21 thought our staff were extraordinary about the way in
22 which they stepped up and responded to those. They were
23 professional and they were committed and I think that
24 gave an awful lot of assurance to the public about their
25 experiences as they went through this as well.

1 I think there are learning aspects about that,
2 having mentioned staff. I do think that we need to
3 ensure that when staff are in normal day-to-day business
4 they have the emotional support and counselling that is
5 available to them. Often that can be delivered on
6 a local basis but I do think we do have national
7 responsibilities to ensure that is in place but it does
8 need to be enhanced and targeted when you are going
9 through such a sustained period of time.
10 We are very used to dealing with major incidents
11 that last for a very limited period of time but not used
12 to this experience of running through a sustained
13 response, that lasted ultimately over two and
14 a half years or so.
15 I just wanted to recognise and thank, though, our
16 staff for the way they did that and the sustained way in
17 which they did it.
18 On practical areas there would be three areas
19 I would highlight which I think would be useful to
20 reflect on.
21 The first one is, I think there is a real need to
22 accept and validate contingencies. The NHS is often
23 having to respond to being productive, efficient, value
24 for money, and all of those are very appropriate. But
25 sometimes there is simply a need to make available and

1 invest in the contingency itself. You can argue that
2 the level of supply that's been made available for PPE
3 is an example of that. Certainly as we go into a future
4 pandemic the requirement to retain testing
5 infrastructure and flexibility is really important and
6 to have available from day one, that is something that
7 would have affected a number of the choices that we
8 could make and the tests that were available were
9 a constraint on the system.
10 But you need to invest and have that available and
11 the NHS is very used to always running hot, always using
12 the available capacity, as you've seen in some of the
13 figures you were sharing earlier on, bed capacity for
14 example.
15 And I do think that specifically in this there is
16 a need for us to ensure that we improve the critical
17 care capacity that is available. We had started that
18 before the pandemic but the levels across the UK need to
19 be raised if they are to be able to respond to a future
20 pandemic that emerges where we are still needing to
21 expand critical care in an extraordinary way. So a very
22 practical recommendation, for me, is to make sure we are
23 able to explain critical care capacity and to make sure
24 that that is available.
25 My second point is that, for understandable

1 reasons, and this is right and proper, there is a lot of
2 focus at the moment on recovering the backlog of the NHS
3 experience. That's particularly reflected through
4 waiting lists and waiting times, and I know that every
5 area of the UK will make progress on reducing the
6 waiting times that were created as a result of the
7 pandemic and will have their own plans in place.
8 What I am concerned about is that we have learnt
9 through the pandemic about the impact of underlying
10 health conditions and characteristics of our population
11 and I would say that in a very practical way there needs
12 to be a recovery plan for health that also forms part of
13 those plans, otherwise we won't be ready for the next
14 pandemic as well.
15 And then my third point that I would reflect on,
16 which would be on the back of my experience, and
17 enhanced through the pandemic is the best support,
18 guidance and direction we gave was when that was done
19 collaboratively across Wales with organisations, with
20 hospitals, with frontline staff. They were always the
21 best because they were reflecting their experiences and
22 they were informed by their experience and their
23 expertise as well. And in the middle of all of the
24 structures that we put in place, just recognising that
25 that was a really significant thing that made

1 a difference to us was our ability to do things together
2 and in collaboration which you would expect, of course,
3 from the NHS on the one hand, but sometimes
4 organisational boundaries can get in the way and it's
5 really important to recognise that we did something that
6 was very exceptional in that capacity during pandemic
7 response.
8 Thank you.
9 **MS NIELD:** Thank you very much. I have no more questions
10 for you, Dr Goodall.
11 **LADY HALLETT:** Thank you, Ms Nield.
12 Mr Wagner.
13 **Questions from MR WAGNER**
14 **MR WAGNER:** Good afternoon, Dr Goodall. I represent the
15 Clinically Vulnerable Families, a group which advocates
16 for the interests of the clinically vulnerable, the
17 clinically extremely vulnerable and their families.
18 The first topic I want to ask you about, please,
19 is IPC, infection prevention and control, measures in
20 healthcare settings. Do you agree, Dr Goodall that it
21 was often necessary for clinically vulnerable patients
22 to visit hospital in person more frequently than other,
23 sort of, non-clinically vulnerable patients?
24 **A.** Just because of their nature, yes, I would accept that
25 they would have to have a contact with health services

1 more frequently than the general population, for
2 example.
3 **Q.** And do you agree that by definition they were more at
4 risk from Covid-19?
5 **A.** They were more at risk from Covid-19. It, of course, is
6 one of the reasons why we introduced criteria in the
7 shielding approach, for example, in Wales and the
8 wider UK.
9 **Q.** At paragraph 293 of your statement you say that
10 in November 2020 the Nosocomial, that is
11 hospital-acquired, Transmission Group, in Wales found
12 that hospital-acquired transmission was increasing in
13 line with community transmission rates, that proper use
14 of PPE in hospitals was limiting the spread between
15 staff and patients but that transmission was happening
16 from patient to patient. Do you recall that finding and
17 that reference in your statement?
18 **A.** I recall the finding and I recall that part of my
19 statement as well.
20 **Q.** Given that those findings are November 2020, what steps
21 were taken to provide additional protections for
22 clinically vulnerable people?
23 **A.** The arrangements were put in place through the
24 Nosocomial Transmission Group. In the report you were
25 describing actually a number of measures were set out

1 that would make a difference to the general infection
2 prevention and control arrangements within our
3 individual hospitals and sites across Wales.
4 We obviously, at this point, were still retaining
5 shielding approaches and they were there to guide
6 a general approach but of course that would still mean
7 that people could be exposed to the hospital
8 environment. The general infection procedures that we
9 had in place would have been expected to be there for
10 all of our patients, including those who were the most
11 vulnerable as well. But on a local basis, health boards
12 were able to ensure that they were adhering to those
13 policies and also ensuring that they were able to track
14 patients who were needing to come into our facilities
15 as well.
16 **Q.** So you've spoken about general measures but was anything
17 specific done to put a ring of protection around the
18 most vulnerable who would be most at risk of Covid-19 if
19 they caught it in hospital?
20 **A.** We had put in the shielding mechanisms that allowed us
21 to highlight those areas. Of course we were trying to
22 ensure that any patient coming into our facilities would
23 feel that they were doing so and were safe as well as
24 ensuring that our staff were able to respond in that
25 way. I don't recall anything specific, nor in my

1 statement, that says so but the range of measures that
2 were introduced, not least in that November 2020 report,
3 would have been intended to show that there were further
4 actions that could take place.
5 **Q.** So the answer is no, there was nothing specific to that
6 group done?
7 **A.** I don't recall anything specific. I could check, but
8 I don't recall it at the time.
9 **Q.** Thank you.
10 In late October 2021 you were informed that
11 nosocomial transmission rates remained particularly high
12 between patients, as opposed to between staff and
13 patients, so the same issue, and that in Wales they were
14 higher than Scotland and arguably higher than England.
15 At that stage, in October 2021, almost a year
16 later, was any particular action taken to put that ring
17 of protection around clinically vulnerable patients
18 because of their particular risk?
19 **A.** As I said earlier, the Nosocomial Transmission Group
20 were still reviewing experiences. There were further
21 measures that the group had introduced: from what had
22 been a guidance role and monitoring, they had actually
23 introduced support, through their group mechanisms, for
24 outbreak management, alongside Public Health Wales and
25 others, but I don't recall anything specifically on the

1 clinically vulnerable in the manner in which you've
2 asked the question. So it would be no to -- the
3 specific answer, but, to the range of actions that were
4 still in place, they were, of course, still being
5 overseen by the Nosocomial Transmission Group.
6 **Q.** So no again. In hindsight, do you accept that, given
7 the particular risk to clinically vulnerable patients,
8 it wasn't enough just to put in general measures, more
9 attention should have been put on putting that ring of
10 protection around the clinically vulnerable in
11 particular in healthcare settings?
12 **A.** Yes, in hindsight, and given your questions, I would
13 agree that they are a group who would have taken
14 additional confidence and assurance about measures that
15 were wrapped around them. I can't describe to you
16 whether health boards, because they had access to the
17 shielding list, did put in local measures because they
18 were operationally responsible, but I do accept if we
19 had made that clearer at national level then that would
20 have helped with the confidence of people coming into
21 our hospitals to have care.
22 **Q.** Not just confidence but also the safety?
23 **A.** Safety and confidence, I agree, yes.
24 **Q.** In September 2020 you advised that visitors to health
25 and care facilities should wear face coverings and that

1 staff who provide direct clinical care of patients
2 should wear FRSM masks, that is surgical masks. Do you
3 recall that, in September 2020?
4 **A.** I don't directly recall it but I was sending out a lot
5 of guidance as well, and that would be the kind of
6 guidance that I would have issued, so I accept that that
7 happened in September.
8 **Q.** Okay.
9 For the Inquiry's reference, it's INQ000392008.
10 I don't think it needs to go up.
11 Is it right that the reason staff providing
12 clinical care were required to wear those FRSM masks
13 rather than just face coverings was as an IPC measure,
14 that is to prevent the spread of Covid between staff and
15 patients?
16 **A.** That would be one of the reasons for it. Obviously
17 clinicians would give advice, and we would be in line
18 with the UK guidance, but, yes, that would be one of the
19 reasons for wearing it.
20 **Q.** Was any consideration given to asking patients to wear
21 masks rather than face coverings, given the relative
22 benefits of masking and the known risk to patients of --
23 the known risk of patient-to-patient spread of Covid-19
24 in hospitals?
25 **A.** I don't recall consideration. You would have to ask

1 colleagues who were in the UK infection prevention and
2 control group. And I don't know whether that would have
3 been reflected in our Nosocomial Transmission Group
4 arrangements but we were always adhering to the guidance
5 that was available, and I don't recall any guidance
6 under consideration that was about providing that level
7 of FFP3 masks to patients, for example.
8 **Q.** I'm sorry, I was asking about FRSM masks, not FFP3.
9 Does that change your answer or not?
10 **A.** Potentially, but I would still say we were issuing the
11 guidance in line with the advice from the UK infection
12 prevention and control, and they were aligning it with
13 the international evidence at the time as well.
14 **Q.** Thank you.
15 I want to move on to the shielding programme and
16 how it was designed. You've highlighted an undated
17 integrated impact assessment on the impact of shielding
18 on vulnerable patients as an important review which was
19 undertaken of the shielding programme. Do you recall
20 that?
21 **A.** Yes, there was an integrated impact assessment that was
22 done of the programme, and there was also one that was
23 done of the food delivery process as well.
24 **Q.** Do you agree that this involved an assessment of
25 providing the support which was implemented, for

1 example, food boxes, medicine deliveries, to those on
2 the shielded list rather than or instead of a full
3 analysis of the impacts of shielding on the clinically
4 extremely vulnerable or any analysis of the
5 appropriateness of the shielding measures selected?
6 **A.** I agree that what it wasn't doing was determining the
7 level of impact, for example, on transmission of the
8 virus and whether it had prevented that. It was about
9 the practicalities and making sure that people who were
10 asked to shield did not feel isolated in respect of the
11 contact and certainly the delivery of the food boxes as
12 you describe.
13 **Q.** Was any wider review undertaken of the shielding
14 programme as a whole, including points like impact on
15 the shielded and the general appropriateness of the
16 design of the programme?
17 **A.** There was some work that was done by Swansea University,
18 where they were looking at a wider range of issues and
19 particularly trying to look if there was any evidence on
20 the impact on the virus but also allowed them to reflect
21 on some of the experiences, such as isolation, as well.
22 **Q.** But that review wasn't undertaken by your department or
23 your government?
24 **A.** That wasn't, no.
25 **Q.** Should such a review have been undertaken, given the

1 very significant impacts of the shielding programme on
2 a large number of people?
3 **A.** Whilst we did those early reviews -- and, you are right,
4 ultimately we were providing shielding advice to about
5 138,000 people -- that would be useful, to have some
6 understanding of the shielding impact beyond those and
7 be able to track it, certainly for future pandemics as
8 well, and I hope the Inquiry will be able to give some
9 reflections on that too of course.
10 **Q.** Will your government be doing any kind of review of that
11 kind?
12 **A.** I've been out of the NHS role for three years on the
13 shielding side. I'm not aware that there is a review
14 being undertaken, just through my permanent secretary
15 experience, but I can certainly check on that.
16 **Q.** Okay, thank you.
17 Finally, I want to ask you about the clinically
18 vulnerable. And when I refer to the clinically
19 vulnerable, I'm not including within -- I'm talking
20 about the wider group, that would also include the
21 clinically extremely vulnerable but the larger group of
22 clinically vulnerable people.
23 In a briefing note prepared for the First Minister
24 on 20 March 2020 it said that, after securing the needs
25 of the shielding population, a team would work on

1 phase 2, identifying wider vulnerable groups and that
2 potential support could be then be provided to them.
3 This is referred to in paragraph 7-8 of your
4 statement. I think it gives the wrong date for the
5 briefing.
6 That wider group of clinically vulnerable people,
7 although not formally shielded, were still provided with
8 stringent advice to keep themselves safe. Are you aware
9 of any steps that were taken or put in place to give
10 additional support to that group, rather than just
11 generalised advice? For example, access to medication,
12 avoiding public spaces, being able to explain their
13 vulnerabilities to employers?
14 **A.** I know that when the chief medical officers were working
15 through their criteria, there was a worry more generally
16 about other people who, if exposed to the virus, would
17 likely be more susceptible.
18 I know that from our approach that we were doing
19 back in March 2020, and we were speaking very rapidly to
20 local authorities and also to the third sector across
21 Wales, we did put a focus there that, despite these
22 particular individuals that we were putting arrangements
23 in, that we did want there to be a wider understanding
24 of others who would still be potentially exposed and
25 would have to follow the guidance as well.

1 But I can't directly respond to your question on
2 the practicalities, but I do recall the third sector
3 conversations and I know that both officials and the
4 sectors themselves wanted to make sure that as much
5 support could be given as was possible.
6 But the food boxes were only accessible for those
7 who were in the higher level of vulnerability.
8 **Q.** CVF, the organisation I represent, are aware from its
9 members that, in practice, many clinically vulnerable
10 people informally shielded to protect themselves due to
11 the level of risk that they felt they were at. But
12 without that statutory support.
13 Did NHS Wales, as far as you're aware, make any
14 effort to monitor that wider group of the clinically
15 vulnerable and their response to the pandemic?
16 **A.** Not as far as I'm aware at the national level. Local
17 health boards would have been more plugged in to the
18 local operational arrangements and the distribution that
19 was happening, and they may well be able to give some
20 evidence that would explain that better.
21 **Q.** My final question. We know that a significant
22 proportion of those who died or suffered adverse effects
23 from Covid-19 were clinically vulnerable but not
24 clinically extremely vulnerable. Do you agree that
25 a better understanding of the way they behaved and how

1 they managed their risks could have informed the
2 delivery and the design of more effective guidance and
3 support for that wider group?
4 **A.** I agree. That would be additional information that
5 would help us, and not just in respect of the experience
6 we've been through but in planning for a future pandemic
7 as well.
8 **MR WAGNER:** Thank you.
9 **LADY HALLETT:** Thank you, Mr Wagner.
10 Ms McDermott.
11 **Questions from MS McDERMOTT**
12 **MS McDERMOTT:** Good afternoon, Dr Goodall.
13 Today I'm asking questions on Covid Bereaved
14 Families for Justice and the Northern Ireland Covid
15 Bereaved Families for Justice.
16 My Lady, if I may, I'm going to take the questions
17 in reverse order as they appear.
18 **LADY HALLETT:** Certainly.
19 **MS McDERMOTT:** Dr Goodall, in your statement of evidence,
20 an initial section entitled "Broad overview and
21 reflections on the Health and Social Services Group and
22 NHS Wales activities during the pandemic period", at
23 paragraph 14 you talk about personal reflections, and
24 under that rubric, at (h), you state:
25 "... it was an ongoing challenge to ensure that

1 governance arrangements recognised the equal status of
2 each of the four nations, and with the establishment
3 of the UK Health ... Security Agency there was
4 a concern that the forum in which the UK Government
5 engaged with [the] devolved nations was ... adjunct to
6 the main decision-making mechanisms."
7 Now, today you've already mentioned in your
8 evidence, this morning, that there was a concern in
9 the early stages that the -- early signs of planning
10 for England having an impact on the supply lines for
11 Wales, but you stated that that didn't really happen
12 in practice and so that's probably something
13 different.
14 My question, and I wish you to focus on this, is
15 that in your statement and in your personal
16 reflections you specify the ongoing challenge to
17 ensure that the governance arrangements recognise the
18 equal status of the four nations, and so my question
19 is this.
20 Can you give some specific examples of the
21 challenges that you refer to?
22 **A.** Yes, so I think they were usefully laid out in the email
23 that I was exchanging in March. So, firstly, in respect
24 of PPE distribution, with all of the positive and good
25 intentions to make sure that there was a UK-wide supply

1 line, and internationally, the danger that, in
2 implementation, that became more about responding to
3 NHS England than it did about the respective
4 NHS arrangements in Northern Ireland, Scotland and
5 Wales. Of course I was concerned for Wales but I was in
6 discussion with others. We were particularly concerned
7 at the outset at the way in which ventilators may be
8 distributed, and going to be in line with the
9 geographical transmission. And with it having started
10 in the south east, and we were a few weeks behind, there
11 was a genuine worry at the outset that the ventilators
12 would go where initially needed rather than where needed
13 over time, and, by the time that you are ending up in
14 the top left-hand corner of Wales, the reality that
15 actually there is nothing left to support those
16 populations. It was really important that we were able
17 to articulate that and, as I said earlier, I did feel
18 that in escalating these concerns, although they were
19 happening practically, that we were able to work that
20 through with colleagues more generally as well.
21 And of course, as we generally make arrangements
22 for the NHS, there is something about the way in which
23 we understand the normal business of the NHS in
24 operation as well, that there is, generally speaking,
25 good contact across the NHS, and I deployed some of that

1 to my advantage during the pandemic itself of course.
2 **Q.** That point takes me to my next question in terms of the
3 contact and communications, and I wonder did you discuss
4 the perception that you had with your counterparts in
5 the devolved nations and whether or not there was any
6 credibility or evidence giving rise to the concerns that
7 the devolved nations and your counterparts may have had?
8 **A.** Yes, I was having discussions, we met regularly and in
9 particular during the first wave arrangements and
10 the second wave arrangements as well. But, yes, there
11 were clearly procurement arrangements that had been put
12 in place that were labelled as "NHS England" and
13 protecting supplies for the NHS in England. And that
14 wasn't just a worry or concern, it was the way in which
15 suppliers were being engaged with as well.
16 So that was the thing that, you know, we needed to
17 keep an eye on for procurement reasons, but it did
18 affect some of our later reflections as well.
19 **Q.** And I suppose then taking you to -- moving forward and
20 thinking about lessons learned, what was the impact of
21 this issue and what lessons can be learned from it to
22 draw forward and taking away, perhaps, a little bit from
23 the direction towards NHS England?
24 **A.** Well, I think that when we are going into this again at
25 a UK level, to be clear where we are making arrangements

1 on behalf of the whole of the NHS rather than just the
2 structures that we have in place that separate
3 NHS Scotland from NHS England and from Wales. I think
4 that's really important for us to work through.
5 What it created at the time was anxiety, in a very
6 rapidly moving position, with modelling that was telling
7 us about the level of beds that were going to need to be
8 available, and a real worry and fear that we were not
9 going to be able to accommodate the patients with the
10 right equipment or consumables that we needed as well.
11 So there were genuine concerns at that time and there
12 was fear at that stage. But I hoped that in the
13 relationships we had and with the contact we had, we
14 were able to de-escalate those concerns pretty rapidly,
15 but it was absolutely a worry in the middle of March to
16 the end of March.
17 **Q.** Thank you, Dr Goodall.
18 I want to take you to a different topic now, and
19 it's in relation to the support for the bereaved
20 families in Wales. In your statement you refer and note
21 the nosocomial Covid-19 programme interim learning
22 report, which was dated March 2023, and you rehearsed
23 the key learning areas identified therein, which
24 included briefed support services, which should be
25 proactively made available in Wales to all families.

1 Now, in a final report -- and I'm not going to
2 take you to it, but for the reference for the Inquiry
3 it's INQ000501402 -- that report, the final report was
4 published in August 2024, and it's obviously after you
5 submitted your statement to the Inquiry.
6 Now, the final report identifies that bereavement
7 services should be proactively signposted and offered to
8 all families who are experiencing grief following the
9 loss of a loved one. My question is this, how is the
10 NHS in Wales ensuring that such support services are
11 being proactively signposted and offered?
12 **A.** I think that question probably is better responded to
13 right now by my successor, who obviously is giving
14 evidence this afternoon. I've not been in the NHS role
15 for three years. We did put in a bereavement strategy
16 that was much clearer, even during the pandemic, in
17 October 2021. I agree with the points that have come
18 out of the learning report as well. It's really
19 important that that very personal experience is
20 provided.
21 The NHS is a service of volume but it always has
22 to make sure it is an individual experience going
23 through it as well, and I think that we can absolutely
24 improve the experiences for patients who are accessing
25 our services and I think that report will be very

1 important in terms of the way forward for the NHS in
2 Wales as well.
3 **MS McDERMOTT:** Very grateful, my Lady, those are my
4 questions.
5 **LADY HALLETT:** Thank you, Ms McDermott.
6 Ms Gowman.
7 **Questions from MS GOWMAN**
8 **MS GOWMAN:** Doctor, I ask questions on behalf of Covid
9 Bereaved Families for Justice Cymru.
10 You told the Senedd in November 2020 that the NHS
11 in Wales was "stuck by the fabric of our hospital
12 buildings and healthcare settings across Wales". You
13 acknowledged at that time that the underlying issue of
14 ventilation was a factor that still needed to be
15 explored and you were hopeful that more could be done.
16 Why had there been a failure to improve the NHS
17 estate in terms of upgrading hospitals to have better
18 ventilation? And what was done immediately to improve
19 ventilations in hospitals following your statement
20 in November 2020, as Wales headed into the second wave?
21 **A.** The estate in Wales is very mixed and we review the
22 backlog of maintenance requirements. We also have
23 health boards in Wales who come forward with their own
24 local plans for how they wish to replace and improve
25 local capacity. Sometimes that can improve new hospital

1 builds. So one of the ways over the years in which
2 we've been able to do that has been able to improve the
3 hospital accommodation by new hospital builds.
4 But our capital that is available to us every
5 year, it's about 300 million a year, is quite limited in
6 its ability to do that at pace and scale across Wales.
7 So ultimately some of the choices that have been made
8 both by health boards and by Welsh Government in support
9 of their decisions would have been constrained by the
10 available funding and finances as well. And I think
11 that will continue to be a problem into the future.
12 On the evidence itself, in respect of ventilation
13 we did have expectations that health boards had to do
14 the best they could within their available facilities,
15 and I know the evidence that Professor Kloer gave
16 yesterday was very powerful in terms of giving an
17 operational insight to what that meant, that there would
18 have been some real constraints for ventilation,
19 particularly during the winter months, for some of our
20 oldest and, you know, ageing estates in Wales, that
21 were, you know, decades old. So that would have been
22 problematic.
23 On the ventilation side, whilst health boards
24 would have had that individual and operational
25 responsibility, we did have an estate infrastructure

1 group. We also had other planning and response
2 mechanisms that were available to work through this
3 guidance, and by this point we also had the Nosocomial
4 Transmission Group that was in place, because we had
5 introduced that in May 2020. But I can't, unless it's
6 clear and available in my statement, put my hand on
7 something that says precisely what happened after
8 November 2020, I'm sorry.
9 **Q.** And to follow on from that point, the national
10 nosocomial end of programme learning report that we've
11 heard about, this was a programme designed to support
12 the NHS Wales organisations to conduct investigations
13 into patient safety and incidence of nosocomial Covid,
14 and that was published in August 2024, and we can see in
15 that end of programme learning report that issues
16 pertaining to the NHS estate in fact persisted
17 throughout the pandemic.
18 Does that not suggest that insufficient steps were
19 taken to mitigate the concerns relating to the NHS
20 estate, despite the fact that you had raised those
21 concerns in November 2020?
22 **A.** It may suggest that, I agree, but it may also, in a very
23 practical way, show the difficulties of individual
24 hospital sites complying with those ventilation
25 requirements, just because of the physical nature of

1 their estate as well. And some of the things that would
2 have changed those would not have been possible during
3 the pandemic response.
4 And equally, some of the answer to some of those
5 older buildings may well just be addressed by, for
6 example, building a new hospital.
7 **Q.** Yes.
8 **A.** And that would not have been something that was possible
9 during the pandemic response anyway.
10 **Q.** But it was important, I'd imagine you accept, to
11 recognise the limitation to appropriately risk assess
12 and to put in place whatever measures could be put in
13 place in light of the limitations around the
14 infrastructure; do you agree?
15 **A.** I agree that would have been an expectation, and
16 operationally we would have expected health boards to
17 put in a whole range of infection control measures to
18 mitigate, but to do it on the basis of the wards and the
19 buildings and the facilities that they had; that's why
20 we couldn't control that at a national level, it had to
21 reflect the local insight and experience.
22 **Q.** But you're not aware of any national oversight in
23 respect of holding health boards accountable for what
24 they were doing on the ground?
25 **A.** Through the group mechanisms that I gave you, through

1 the planning and response cell arrangements, which had
2 health board representation, and as I said there was
3 an estates infrastructure group that usefully had been
4 dealing with a number of the areas, including the
5 original issues around oxygen supply, for example, and
6 that was retained through the pandemic response as well.
7 **Q.** Staying with the end of programme learning report, do
8 you accept the report fails to deal with key issues, for
9 example it fails to investigate causes for cluster
10 outbreaks on wards and the closure of primary and
11 emergency care services due to cluster outbreaks?
12 **A.** It may not have been the purpose of that report but
13 I agree that they are described as not being handled and
14 dealt with. But that of itself would be useful
15 information still to find even if it's through
16 a different mechanism.
17 **Q.** Finally on nosocomial transmission, many of our members
18 witnessed healthcare workers failing to adhere to IPC
19 guidance with regards to PPE. This is also recognised
20 by Steve Ham, the chief executive of Velindre University
21 NHS Trust, who discusses in his statement what he's
22 called compliance/complacency fatigue amongst staff.
23 What measures were taken at national level to ensure the
24 NHS health boards and trusts were properly enforcing the
25 use of PPE by healthcare workers?

1 **A.** Firstly, to make sure that the national guidance was
2 provided, the PPE guidance was always issued at a UK
3 level and of course then transmitted and communicated
4 within our Welsh structures, so just important that we
5 were able to do that very regularly.
6 Secondly, to learn from outbreaks that occurred,
7 initially in the first months of our experience,
8 Public Health Wales had a very prominent role on that.
9 Later, even though Public Health Wales continued to
10 give that support, we used the Nosocomial Transmission
11 Group for doing that. And the reports that the
12 nosocomial group produced, including those attached to
13 my statement, we spoke earlier about the November 2020
14 guidance. That was itself clear that we still had
15 concerns about some of the adherence of staff,
16 particularly in areas that were in non-clinical areas,
17 rather than the clinical areas themselves.
18 So we focused on that. We met with unions. We
19 met with our partnership forum and we tried to make sure
20 that as much support nationally was available on that
21 guidance but, ultimately, that became a matter for
22 health boards operationally to deliver, and for them to
23 work with their staff, of course, to wear the
24 appropriate PPE, as I would expect myself.
25 **Q.** Thank you, Doctor. My next topic is capacity and you've

1 touched upon this at length in questions from the CTI.
2 But just picking up on a couple of points. Your
3 evidence has touched upon the fact that there were
4 patients who may, under normal circumstances, have gone
5 to critical care but instead were cared for elsewhere in
6 hospital on various hospital wards. The intensive care
7 expert Professor Summers gave evidence as to the
8 importance of care being delivered on a critical care
9 unit due to factors such as staffing ratios and the
10 experience and qualifications of the care providers.
11 Do you agree that patients in Wales who were
12 critically ill but managed outside of critical care were
13 put at risk?
14 **A.** Anybody who was not in the normal critical care
15 environment may have been exposed to risk. I'm not
16 aware of any experiences that were described where that
17 was the case through the health boards or that were
18 brought to my attention. But, clearly, with the really
19 exceptional arrangements we put in place to go beyond
20 our historical capacity of 152, it's a very different
21 experience to be caring for somebody with a normal
22 nursing ratio in a critical care ward than it is in
23 a theatre that has been set aside that can be used that
24 is providing good quality care but outside of that
25 environment as well.

1 I think it's important to recognise, and this is
2 not for invasive ventilation, there were patients who
3 were able to be cared for in a different way with some
4 of our respiratory wards and supported the use of CPAP
5 machines as we learnt about that treatment. But I do
6 agree with the basic point which is we would wish to
7 retain as many patients as possible in a traditional
8 critical care unit environment even if that unit is
9 expanding.
10 **Q.** And similarly, the Inquiry has heard evidence on the
11 importance of staffing ratios in critical care and that
12 critical care capacity is not simply a question of
13 available beds. The evidence of Jean White was that
14 staffing ratios were diluted in Wales and this was
15 particularly acute during the second wave.
16 Do you agree that that in itself demonstrates that
17 the critical care capacity in Wales was stretched?
18 **A.** Well, bluntly, I would say the critical care capacity in
19 Wales was stretched, I agree, and not just because of
20 the ratios but because of the exceptional efforts of the
21 staff and the way in which they were being asked to
22 manage these patients, but the staffing arrangements
23 were really important. We were looking to expand based
24 on the pressures that we were experiencing. I know
25 Jean, in her evidence, also commented on the moments

1 when we were concerned about some of those nursing
2 ratios and actually introduced national guidance to step
3 back from some of the more extreme ratios that may have
4 been used but were never used in Wales.
5 **Q.** And finally on this point, and drawing together the
6 consequences of that stretching, IFF Research that
7 the Inquiry has received demonstrates that healthcare
8 workers felt pressure to make decisions about critical
9 care. This is supported by expert evidence which has
10 been given to the Inquiry that clinicians were likely
11 making conscious and unconscious decisions on the ground
12 not to escalate to critical care in times of stretched
13 capacity and resources.
14 Did your analysis as to the saturation of critical
15 care in Wales consider or take into account that
16 clinicians might have been making different decisions
17 about escalation of treatment than they would have been
18 in peace time?
19 **A.** It would be easier to receive that as direct evidence
20 from the clinicians concerned. I know that was one of
21 the worries about our moral and ethical group which was
22 reviewing the criteria that we wanted to apply.
23 Certainly wherever a critical care bed was asked for and
24 when it was beyond the capacity of the critical care
25 department itself, the advice I received was that we

1 were always able to accommodate those patients. But you
2 are right that clinicians can make individual decisions
3 based on the pressures that a hospital site, for
4 example, is under, and we were under very significant
5 pressures during the first wave, particularly in April,
6 and we were under highly significant pressure in
7 the second wave, particularly in December and as
8 I remember it, in a very difficult place in
9 January 2021.
10 Q. If the potential for conscious or unconscious
11 decision-making and the impact of that on escalation of
12 treatment was something that was a concern of the
13 ethical group, what did the ethical group do about it to
14 mitigate those risks?
15 A. I don't know. I would have to check on that. On
16 an ongoing basis they were issuing support and guidance
17 into it at that stage and looking to give support.
18 I know that the technical advice group also produced
19 some supporting information for our workforce in Wales,
20 basically on the judgments and the risks that they were
21 being exposed to, and I haven't got it to hand but I'm
22 very happy to give that reference to the Inquiry because
23 it was a way in recognising that personal impact on
24 clinicians making decisions as well.
25 Q. Thank you, Doctor. Moving on to the use of field

1 hospitals. You say in your statement that the use of
2 field hospitals was limited and that this was one
3 indicator of what you deemed to be the success of
4 measures taken by the Welsh Government.
5 You gave evidence during Module 2B that the
6 decision to discharge patients into care homes without
7 a Covid-19 test was a ministerial decision intended to
8 "help the NHS create capacity". Why didn't you free up
9 capacity by discharging vulnerable people into step down
10 facilities as opposed to care homes? Couldn't the use
11 of field hospitals have served that purpose?
12 A. So, firstly, the advice was about expediting discharge
13 more generally rather than only to a care home
14 environment. Many of the patients who were discharged
15 were actually discharged to a home environment and with
16 support. In March, when that guidance was being issued,
17 and even in April, we were still developing plans that
18 we could rely on for field hospital use, some of the
19 beds that were being extended and made available
20 during April weren't directly in field hospital
21 facilities, so at that stage we weren't able to use the
22 field hospital facilities because they were still under
23 construction in most of the health board areas as
24 I recall.
25 Q. Is this something that happened subsequently then, field

1 hospitals as step-down facilities?
2 A. Well, field hospitals were used as step-down facilities
3 for individuals who had been through a Covid pathway.
4 I think one or two of the health boards may have used
5 them for general step down when they were under more
6 pressure but they were never used for the acute receipt
7 of the patients and the model that we developed in Wales
8 was always about trying to deal with patients once they
9 were ready to move to that alternative environment as
10 well.
11 Q. And in a similar vein, and you've been asked about the
12 report in November 2020, it was recognised at that point
13 that nosocomial transmission in Wales had increased,
14 a number of concerns regarding implementation of IPC
15 measures in hospitals and a lack of available space to
16 create low risk or green sites in the Welsh hospitals.
17 Again, why weren't the field hospitals used to mitigate
18 against those challenges?
19 A. The field hospitals were temporary facilities. They
20 were set up as a contingency to be available. We had
21 other capacity available within our hospitals to use at
22 that time and even during November into December 2020
23 there was still available capacity within our hospital
24 systems and we did allow health boards, of course, to
25 make some of their own decisions about those areas, but

1 due to their temporary nature, for general patients
2 there would have been some limitations on their use.
3 They were always there as an ultimate contingency
4 because we had wanted, if we'd seen the modelled levels
5 coming through, to make sure every patient, whatever the
6 workforce practicalities we needed to put in place,
7 would at least be accommodated in a bed.
8 So I just think it was for a different purpose and
9 in that autumn period we still needed to retain the
10 field hospital flexibility because we were seeing the
11 numbers rise again.
12 Q. Isn't another interpretation of field hospitals being
13 under-utilised that the resources were not being
14 exploited to their full extent rather than they were not
15 needed?
16 A. I would say that the reason that we didn't use field
17 hospitals as originally intended was because we were
18 able to have confidence in the lockdown measures that
19 occurred when that was announced in the last week
20 of March and that we started to see the change in the
21 transmission across Wales. If lockdown hadn't happened
22 the field hospitals could well have been in use and we
23 may well have ended up seeing scenes that were similar
24 to those that we were seeing from Italy, for example,
25 and other European countries and we had wanted to

1 mitigate that.
2 Because we had never locked down the whole of our
3 society, we wouldn't have had the confidence that we
4 were going to see that kind of impact and that's why we
5 needed to have that preparation available.
6 For future, we would have learnt an awful lot more
7 in a different pandemic about using available capacity
8 in a different way, the field hospital model and how it
9 could be used. And I know our clinicians would have
10 their own views on whether they could be used for other
11 alternative mechanisms as well.
12 **Q.** Moving on to my final topic, access to GP services. At
13 paragraph 738 of your witness statement you state that
14 you were not aware of any specific difficulties with
15 patients using the video consultation service that was
16 rolled out to all GP practices in Wales.
17 Many of our members reported GPs being hard to get
18 hold of and not offering virtual appointments when they
19 should have been, and these concerns were widely
20 reported in the press up to as late as September 2021.
21 In addition, the Public Services Ombudsman for Wales
22 raised several issues with GP services in Wales
23 including a failure to provide virtual appointments for
24 vulnerable individuals, and service failures in lack of
25 face-to-face appointments.

1 With those comments in mind, do you agree that --
2 given there were clear difficulties with the services
3 that these were issues that you should have been
4 aware of?
5 **A.** They were issues that we were made aware of in the way
6 in which you said. The operational use of the systems
7 were for every individual GP practices, they were
8 supported by their health boards to implement that. We
9 wanted to make sure that the platform was available at
10 a national level to give that flexibility. Primary care
11 was an essential service and it was really important
12 that it was kept open throughout the pandemic.
13 I do know of moments when GPs themselves had
14 problems either with their branch surgeries or in fact
15 with an individual surgery being unable to open because
16 of staff off sick with Covid, for example, but I believe
17 that the technology should be used but I think there
18 should also be a route for patients to access face to
19 face when it's required also.
20 **Q.** Finally, we know no formal impact assessment was
21 undertaken for digital inclusion and considerations of
22 recommendations on the elderly, disabled and those with
23 language or digital access issues were not always
24 explicit in the submission of advice or recommendations
25 to the Minister for Health and Social Services. Given

1 that these were considerations that had been part of
2 Wales' strategy for digital health since as long ago as
3 2015, shouldn't they have been easily identified?
4 Shouldn't they have been at the front and centre of
5 advice to ministers?
6 **A.** Yes, they should have, you're right, the previous
7 strategies were there, we also incorporated that in the
8 revised digital strategy in 2021 also in those early
9 weeks and months. We were moving so rapidly on a range
10 of different areas that some of those impact assessments
11 were not done as we would wish but we were able to
12 ensure, as we went through the pandemic, that those were
13 discharged as we went forward and, as I said earlier,
14 the concerns on the exclusion areas, digital exclusion
15 in particular, I hope that we were able to ensure at
16 least another platform was available, that there were
17 other operational routes for patients to have access as
18 well.
19 **MS GOWMAN:** Thank you, Doctor, those are my questions.
20 Thank you, my Lady.
21 **LADY HALLETT:** Thank you very much, Ms Gowman, very
22 grateful.
23 That completes the questions we have for you,
24 Dr Goodall. I apologise, again, for having to bring you
25 from yesterday to today and also, obviously, for the

1 imposition that the Inquiry makes upon you and your
2 department and all your colleagues. So thank you very
3 much for your help. And I promise to make sure we get
4 through Ms Paget's evidence today so she doesn't get
5 adjourned overnight.
6 **THE WITNESS:** Okay, thank you, my Lady.
7 **LADY HALLETT:** Thank you.
8 **(The witness withdrew)**
9 **LADY HALLETT:** Very well, I shall return at 1.45.
10 **(12.45 pm)**
11 **(The short adjournment)**
12 **(1.45 pm)**
13 **LADY HALLETT:** Mr Mills.
14 **MR MILLS:** My Lady, may I call Judith Paget, who can be
15 sworn.
16 **MS JUDITH PAGET (sworn)**
17 **Questions from COUNSEL TO THE INQUIRY**
18 **LADY HALLETT:** I'm sorry if we've kept you waiting,
19 Ms Paget.
20 **A.** No, it's fine.
21 **LADY HALLETT:** I suspect you've been here since this
22 morning, haven't you?
23 **A.** I have, my Lady, but it's absolutely fine.
24 **LADY HALLETT:** Weren't you here when I arrived?
25 **A.** I was.

1 **LADY HALLETT:** I'm really sorry that you waited so long.
2 **A.** No problem.
3 **MR MILLS:** Your full name, please.
4 **A.** Judith Ann Paget.
5 **Q.** Mrs Paget, you have provided two statements to this
6 module of the Inquiry.
7 For reference, they are INQ000486014 and
8 INQ000485240.
9 **A.** That's correct, Mr Mills.
10 **Q.** You are the CEO of NHS Wales and the Director General of
11 the Health, Social Care and Early Years Group?
12 **A.** That's correct.
13 **Q.** The latter was, during the pandemic, known as the Health
14 and Social Services Group?
15 **A.** It was.
16 **Q.** A little bit about your background. From June 2014
17 to October 2021 you were the CEO of Aneurin Bevan
18 University Health Board?
19 **A.** Correct.
20 **Q.** After which, in November '21, you were appointed as the
21 interim CEO of NHS Wales?
22 **A.** Correct.
23 **Q.** A role to which you were permanently appointed
24 in June 2023?
25 **A.** That's correct.

1 **Q.** Can we start, please, with the data NHS Wales received
2 about Covid-19 infections and deaths during the
3 pandemic.
4 Let us deal with NHS staff first. At
5 paragraph 448 of your statement you say that the Welsh
6 Government regularly received data on the number of NHS
7 staff who were absent for reasons due to Covid-19, but
8 that data did not, however, record whether the member of
9 staff had contracted Covid-19 whilst at work; is that
10 right?
11 **A.** That's correct.
12 **Q.** In the same paragraph, you say the Welsh Government does
13 not hold or publish official or verified data on the
14 number of NHS staff who died from Covid-19.
15 **A.** That's correct.
16 **Q.** Please can we have a look at INQ000475209.
17 This is the statement made by Professor Kloer on
18 behalf of Glangwili General Hospital who the Inquiry
19 heard from yesterday. At paragraph 50 we read that the
20 hospital experienced one staff death attributable to
21 Covid which was acquired within the community and not
22 whilst at work.
23 Before I ask you about that, let us also look at
24 INQ000480136.
25 This is a statement from the University Hospital

1 of Wales, and at 62 we read that the health board was
2 able to say that they sadly lost six members of staff
3 who died following contracting Covid-19. Three of those
4 worked at the hospital, one a surgeon, one a theatre
5 assistant, and one a nurse.
6 It's a small sample, of course it is, but it would
7 appear, would it not, that staff deaths were being
8 recorded by the local health boards?
9 **A.** Well, I think my view would be at a local health board
10 level they would know whether they'd lost members of
11 staff and that would be correct. What I understand to
12 be the case was that there was no official mechanism for
13 the number of deaths to be recorded and reported
14 officially to Welsh Government and recorded on a Welsh
15 Government system.
16 My understanding is that Welsh Government relied
17 on the ONS data in order to advise them on the number of
18 healthcare workers who lost their lives during the
19 Covid-19 pandemic.
20 **Q.** We'll look at the ONS data in respect of patient deaths
21 in a moment, but can I ask you this, please. Do you see
22 the absence of an official mechanism for the number of
23 deaths to be recorded and reported officially to the
24 Welsh Government as being a serious issue?
25 **A.** So I think my view would be that the ONS data capture is

1 well established and a reliable mechanism for recording
2 information, and so I can understand completely why
3 Welsh Government at that time relied on that as the
4 evidence source. I think that in future arrangements it
5 clearly would be helpful to know and understand the
6 impact and recording of staff impacted by Covid-19 or
7 any other pandemic, but I think that what would be
8 really important to understand is the reliability of
9 that data because clearly organisations will be
10 reporting their understanding. You might have a member
11 of staff in your organisation who sadly lost their life
12 in a community or in a neighbouring health board, so
13 it's really about making sure that any data capture
14 system can be relied upon.
15 **Q.** Can I ask you about patient deaths. At your
16 paragraph 450 you say that the Welsh Government did not
17 produce its own Covid-19 mortality data during the
18 pandemic, instead relying on two sources. What were
19 those two sources, please?
20 **A.** The one source was a data capture that Public Health
21 Wales had introduced and I recall this because obviously
22 previously I was the chief executive of Aneurin Bevan
23 University Health Board. I recall that
24 Public Health Wales asked us to ensure that on a daily
25 basis we completed a pre-prescribed form to provide them

1 with details of any person who'd died in our care in the
2 previous 24 hours, which we did, and sent that to them
3 on a regular basis.
4 And then the second data capture was, again, the
5 ONS survey data.
6 **Q.** Can I just ask you about the first, then we'll come to
7 the second. It's right, is it not, that the rapid
8 surveillance data, what the first was called, suffered
9 from systematic underreporting during the early stages
10 of the pandemic?
11 **A.** I can't comment on that. My experience in the health
12 board that I worked in at the time was that we made
13 absolutely rigorous efforts to ensure that the data was
14 captured and verified and submitted. I can't comment on
15 what happened with other NHS organisations.
16 **Q.** I'm just at your 454, and of course appreciating that
17 you've had assistance in drafting this statement, but we
18 do read, first sentence of your paragraph:
19 "Systematic under-reporting in the
20 Public Health Wales rapid surveillance data was
21 identified during the early stages of the pandemic."
22 Are you able to share with us any of the reasons
23 identified for that underreporting?
24 **A.** I'm afraid I'm not. It would be speculation on my part
25 if I did.

1 **Q.** The ONS data then, can you help us, how did that come to
2 the Welsh Government?
3 **A.** I didn't work in Welsh Government at that time but our
4 statistics team get regular feeds of information from
5 accredited sources, one of which would be ONS.
6 **Q.** At your 456 you explain the ONS mortality data is based
7 on death registrations and coroners' reports.
8 **A.** Yes.
9 **Q.** At 455, above it, you explain that it was published on
10 a weekly basis. Was there a disadvantage in having that
11 data only as regular as every week?
12 **A.** So my understanding based on the explanations that I was
13 given at the time, clearly not in Welsh Government, was
14 that Public Health Wales wanted a more timely reporting
15 of deaths in NHS facilities, and that was why we were
16 asked to do the rapid surveillance and submit that on
17 a daily basis.
18 **Q.** Can we think then about your time as CEO. Soon after
19 your appointment in November 2021 you were tasked with
20 leading the response to the Omicron variant.
21 **A.** Yeah.
22 **Q.** Reflecting on that time now, did you have the data you
23 needed at your fingertips in respect of NHS staff who
24 contracted Covid-19 at work, staff who died from
25 Covid-19, and patient deaths from Covid-19?

1 **A.** Going through the three, we would -- I would have relied
2 on the ONS data in relation to patient deaths. We had
3 a regular feed of information from the NHS in relation
4 to staff absence, including staff absence from Covid-19.
5 We would not have had data about whether or not Covid-19
6 had been contracted in a work situation or in
7 a community situation because it was impossible to know
8 that for sure.
9 **Q.** Yes, understood. Can I ask you this, please, before
10 looking forward to improvements or changes that have
11 been made. When you arrived in post in November 2021,
12 were you surprised to discover that this data was not
13 being actively collected by NHS Wales itself?
14 **A.** I was -- I did ask questions about data availability.
15 Clearly I was given the information that I've just
16 relayed to you, and I accepted those explanations from
17 colleagues around making sure that the data we had was
18 from a reliable and validated source, so I accepted
19 those explanations.
20 **Q.** Can I ask you then what has been done to improve the
21 collection of data in Wales in readiness for a future
22 pandemic?
23 **A.** So, in relation to patient deaths, then we would
24 continue to use the ONS data, and there has been no
25 changes to that. In relation to staff health and

1 sickness, we are implementing a new electronic staff
2 record that would allow us to have a more reliable
3 capture of information in relation to staff well-being
4 and sickness absence levels.
5 **Q.** Next, please, palliative care. At paragraph 382 of your
6 statement -- it's page 134, Mrs Paget. I'll let you get
7 to it.
8 **A.** Bear with me, sorry.
9 **Q.** Take your time.
10 **A.** Did you say 382?
11 **Q.** It's paragraph 382, yes.
12 **A.** Okay, found it, thank you.
13 **Q.** You say:
14 "The Welsh Government required that palliative and
15 end of life care in all hospital settings must continue
16 [during the pandemic]."
17 And you go on, at 383, to say:
18 "[You are] not aware of any specific reports which
19 were brought to the attention of the Minister for Health
20 ... regarding any failures to meet this requirement or
21 of any particular instances of Covid-19 patients failing
22 to receive palliative care ..."
23 **A.** That's correct.
24 **Q.** I'd just like us to look at two documents and consider
25 how reassured you are by the absence of specific reports

1 to the minister that palliative care was not maintained.
2 The first, please, is INQ000182461.
3 Document titled "Maintaining Essential Health
4 Services during the COVID-19 Pandemic - summary of
5 services deemed essential".
6 If we move to page 22 we find a section on
7 "Palliative and End of Life Care". From the fifth line
8 down on this paragraph we read:
9 "Access to admission for palliative care
10 purposes where necessary, to inpatient specialist
11 palliative care expertise, and to palliative
12 interventions should be preserved where it is possible
13 and safe. This must be judged according to the local
14 context."
15 Do we understand from this that the instruction
16 gives the local health board or even a hospital within
17 the board discretion to decide not to admit a patient
18 for palliative care if it is deemed not possible, not
19 safe to do so?
20 A. That would be the interpretation of that. In practice,
21 based on my own personal experience of course, our teams
22 would have done whatever possible to meet the wishes of
23 a patient and their family in terms of palliative care.
24 So, absolutely, clearly if there were situations where
25 it was judged to be unsafe for that individual to be

1 admitted, then clearly they would've made arrangements
2 to have appropriate and effective care in another
3 setting. But the wording of the paragraph suggests
4 that.
5 Q. Yes.
6 Can we look, please, at INQ000469089.
7 This is an email chain from February 2021. It
8 didn't involve you, it involves your predecessor --
9 A. Yes.
10 Q. -- and Dr Goodall. But it considered a number of
11 lessons learned in respect of palliative care. If we
12 look at the paragraph beginning "Key lessons learnt", in
13 the second sentence we read this:
14 "Most palliative care units are not well set up
15 to control transmission."
16 Can you just help us understand this observation,
17 please. Is this a comment on perhaps the size of most
18 palliative care units? The level of ventilation?
19 A. Yes -- I mean, the palliative care units will be located
20 in local hospitals, so any implications around the
21 condition of that estate, the availability of
22 ventilation, et cetera, would impact on palliative care
23 units in the same way as it would impact on other parts
24 of the hospital.
25 Q. Six lines up from the bottom of this paragraph we have

1 this:
2 "We know a bit more about what really matters
3 (good medical care, good symptom control, but also
4 individualisation, human presence and flexibility in
5 approach) and what doesn't ..."
6 And I'd like to focus on this:
7 "... (being too risk averse to protect
8 ourselves)."
9 And if we recall that access to palliative care
10 depended on a local assessment of whether it was safe,
11 does what we read in this paragraph give rise to concern
12 that people were not always provided with palliative
13 care because the units were not well set up to control
14 transmission, and there appears to be a recognition here
15 that those managing the units have, on occasion, been
16 too risk averse in order to protect themselves?
17 A. I'm not sure I can comment on that because I don't
18 really know what was in the thinking of the person when
19 they committed that to writing.
20 Q. This is an email chain from February 2021. Can you help
21 the Inquiry, have there been any other reviews into
22 lessons learnt in respect of administering and
23 maintaining palliative care during the pandemic?
24 A. Yes, certainly. We have established a national
25 programme, a forum that brings experts, clinical experts

1 and patients and their representatives together to
2 understand what worked well and what didn't work so well
3 during the pandemic, and as a result of that a quality
4 statement has been published by Welsh Government which
5 clearly sets out what good looks like for palliative
6 care in Wales. The person who drafted this email is
7 actually the national clinical lead for palliative and
8 end-of-life care in Wales and is a key contributor to
9 that work.
10 Also, if I could say that as a result of learning
11 during the pandemic, the Welsh Government included two
12 commitments in their programme for government which
13 related to palliative care and one was to ensure that we
14 reviewed hospice funding in Wales. And as a result we
15 provided -- or Welsh Government provided additional
16 resource. But also that that strengthened focus on
17 palliative and end-of-life care should continue and, as
18 a result of that, investments have been made in
19 additional specialist clinical nursing staff to work on
20 weekends, additional district nurses to support people
21 at weekends as well. So there has been additional --
22 there has been learning but also changes made as
23 a result of that.
24 Q. Can we move to DNACPR, please. It's right, is it not,
25 that Wales has its own policy in this area, that's the

1 All Wales DNACPR policy?
2 **A.** That's correct.
3 **Q.** DNACPR decisions, being a clinical one, can you help
4 the Inquiry understand what the purpose of the All Wales
5 policy is?
6 **A.** So the purpose of the policy is to set out a very clear
7 framework to guide clinicians in the application of
8 DNACPR in Wales.
9 I'll come back to any subsequent questions that
10 you might ask me.
11 **Q.** The version of the policy in place at the start of the
12 pandemic was the 2017 policy?
13 **A.** That's correct.
14 **Q.** That was updated in 2020?
15 **A.** That's correct.
16 **Q.** Can you help us with when in 2020?
17 **A.** I think it was towards the latter half of the year but
18 I would have to check the accuracy of that.
19 **Q.** And it was updated again in 2022, by which time you were
20 the CEO of NHS Wales?
21 **A.** That's correct.
22 **Q.** How is this policy disseminated to local health boards
23 in order to ensure consistency of approach in this area?
24 **A.** So we have a national group that oversees the
25 development of the policy and all subsequent materials

1 to support the implementation of the policy. That group
2 will disseminate the revisions to the policy, or any
3 changes to forms, documentation, or advice to every NHS
4 organisation.
5 The group have also provided educational
6 materials, seminars, training to care homes, staff
7 training modules on our electronic training records.
8 There is e-learning elements as well, and all of the
9 materials, both the policy and the supportive materials
10 and video explanations and advice is all on a single
11 website available to everybody.
12 **Q.** Are you aware of the concerns that had been raised by
13 both patients and those who lost loved ones about DNACPR
14 practices during the pandemic?
15 **A.** I am aware, yes.
16 **Q.** And that those concerns, as the Inquiry has heard,
17 extend to DNACPR notices being issued in a blanket
18 fashion to, for example, fit and healthy disabled people
19 of working age; notices being issued without
20 consultation, with either the patient or a family
21 member; and that there were instances of DNACPR notices
22 being confused with Do Not Treat notices?
23 **A.** I am aware of those concerns.
24 **Q.** I'd like us to consider, then, what has been done in
25 Wales to try to get to the bottom of this issue.

1 Can we go, please, to INQ000485929.
2 This is the review performed by Healthcare
3 Inspectorate Wales. It was performed during 2023 into
4 DNACPR decisions and it was published earlier this year.
5 **A.** I believe so. I thought it was published in October '23
6 but, again, I would need to check that.
7 **Q.** Can I ask you this, please. Did NHS Wales commission
8 this review and, if not, how did it come about?
9 **A.** I think it was requested so I think we requested that
10 Health Inspectorate Wales undertake the review to inform
11 the ongoing learning and understanding around DNACPR
12 policy and application in Wales.
13 **Q.** If we turn to page 11, please, we have an explanation of
14 what the Healthcare Inspectorate did. Under "Scope and
15 Methodology" we read at the first bullet point that the
16 review considered DNACPR forms submitted by the health
17 boards themselves. Then second bullet point, further
18 DNACPR forms were read and compared to clinical records
19 on site. That was at two health boards.
20 We know from elsewhere in the report that a total
21 of 280 forms were reviewed, 66 of which were the ones
22 reviewed alongside clinical records.
23 Looking at this list in respect of the forms, it
24 doesn't appear to say here that the forms reviewed were
25 ones that were in fact completed during the pandemic.

1 Are you able to help us?
2 **A.** I'm sorry I can't, no.
3 **Q.** Do you agree that it doesn't make that clear?
4 **A.** I do agree.
5 **Q.** From the bottom of this page we learn that the
6 Healthcare Inspectorate launched two surveys, one for
7 staff and one for patients. We have under the staff
8 survey a total of 65 responses and in response to the
9 public survey a total of 32 responses. Taking all of
10 this together, a total of 97 responses to the surveys,
11 280 forms chosen by the health boards, 66 of which were
12 reviewed alongside clinical records. No indication on
13 the face of it that the forms reviewed were in fact
14 completed during the pandemic.
15 Given the scope of this review has it allowed
16 NHS Wales to gain a comprehensive understanding of
17 DNACPR practices in Wales during the pandemic?
18 **A.** So my view would be that it is one element of
19 a contribution to that understanding. It doesn't stand
20 alone and it doesn't stand as being the total work to
21 review this. My understanding is that every NHS
22 organisation is required to do its own local audits of
23 the application of the DNACPR policy and that's
24 undertaken by local resuscitation teams.
25 It's further my understanding that quite recently

1 an event was undertaken to review DNACPR to undertake
2 a thematic review where all the learning from those
3 audits was brought together --
4 **Q.** I'll ask you about those other reviews in a moment if
5 I may.
6 **A.** Okay.
7 **Q.** Can I first ask you about two recommendations that did
8 come out of this review. Please can we go to page 7.
9 In the first paragraph starting on the fifth line
10 down, we read this:
11 "We found some forms and clinical records either
12 contradicted each other, were incomplete, or there was
13 no evidence that a mental capacity assessment had been
14 undertaken and without rationale. We are therefore
15 not assured, based on the records we reviewed, that
16 the DNACPR decision-making process is always completed
17 in line with the all-Wales Policy, for patients who
18 were deemed to lack capacity. This issue must be
19 addressed by the health boards and trusts."
20 Notwithstanding that last sentence, can I ask you
21 this. What, if anything, has NHS Wales done in response
22 to this particular finding?
23 **A.** So, further audits have been undertaken and shared
24 across Wales. The learning from this report, alongside
25 learning from other reviews undertaken, has obviously

1 been taken into account with a subsequent change to the
2 policy which is about to be issued.
3 But I do know that further letters were sent to
4 NHS Wales organisations drawing to their attention the
5 concerns around those particular things, particularly
6 the signing of forms, the -- making sure that forms were
7 legible, and to make sure that in the local audits that
8 were undertaken that attention was paid to these
9 particular issues.
10 **Q.** The last thing from this report then, please. Can we go
11 to page 37. At the bottom of the page, where we have
12 the bullet points, the Healthcare Inspectorate
13 recommended the creation of an electronic repository of
14 DNACPR decisions. We have three benefits here: improved
15 documentation of key clinical details about the DNACPR
16 decision, in one accessible system; immediate
17 notification to ED staff when a patient arrives in
18 an emergency; immediate notification if a DNACPR
19 decision is cancelled.
20 Over the page, to add to these three points we
21 have risks they say would be mitigated by an electronic
22 repository, the need to document additional information
23 in clinical records, physical loss of DNACPR forms,
24 other healthcare providers not being alerted to a DNACPR
25 decision.

1 Can I ask you this, please, has NHS Wales created
2 or indeed begun to create an electronic repository of
3 DNACPR decisions?
4 **A.** Welsh Government accepted that recommendation as having
5 strong merit. Work has begun to understand how that
6 might be developed. I don't have any further
7 information on the progress to that.
8 **Q.** You have referred to other reviews having taken place in
9 this area. Could you share with the Inquiry, please,
10 what those reviews considered and any findings that you
11 consider the Inquiry ought to hear.
12 **A.** So the NHS Wales Executive brought together colleagues
13 from across NHS Wales to develop and consider the themes
14 coming from those local audits. They brought together
15 cases from January 2022 to January 2023 and shared the
16 results of their local audits with each other.
17 Their work also included feedback from the medical
18 examiner service in terms of their review of nearly
19 7,000 deaths, picking out, again, those themes that
20 related to DNACPR that featured in about 3% of those
21 reviews.
22 Again, the themes were consistent with some of the
23 things that you've mentioned earlier, so forms not being
24 signed in the correct place, sometimes not completed,
25 and sometimes the information about the nature of the

1 conversations with families that had taken place not
2 fully documented. So that was one, and a number of
3 relations have been made from that which will then
4 feature in the updated DNACPR policy that's currently
5 being reviewed.
6 And then the other one was the end of programme
7 learning report on nosocomial transmission in hospitals
8 that was published earlier this year also considered
9 DNACPR and took some of those thematic reviews as well.
10 So those are the three: the HRW report; the mortality
11 review, thematic review; and the end of programme
12 report.
13 **LADY HALLETT:** I'm sorry to intervene, but -- so you
14 obviously got plenty of evidence that things aren't
15 going right and you need to do something and you've had
16 the recommendation Mr Mills has put to you that that you
17 say has been accepted by the Welsh Government about
18 an electronic repository which might avoid these things
19 happening and make life a great deal better for the
20 families of people upon whom these notices have been put
21 and indeed for the patients themselves. But when
22 Mr Mills asked you what's been done to create it, you
23 said the Welsh Government's accepted it but then you
24 used this expression "Work has begun to understand how
25 that might be developed". That doesn't sound very

1 specific to me. And what I'd like to know is, what do
2 you mean by "Work has begun to understand how that might
3 be developed"? What has happened, as opposed to having
4 reviews, meetings, plans? I want to know what's
5 actually happened to make a repository happen.
6 A. So, as far as I know, my Lady, it's our policy team, who
7 are supporting all the work on DNACPR and related
8 matters -- is working alongside our digital team to work
9 out how they can make that system happen, how it can
10 link across NHS Wales, how it will link into existing
11 data systems, so patient administration systems,
12 et cetera, and how we can develop something that we can
13 put in in a reliable basis.
14 What I don't know, my Lady, is where we are in
15 terms of that progress to be able to report to the
16 Inquiry today.
17 **LADY HALLETT:** And we have no suggested timeline?
18 A. I don't. But if it would be helpful, I can determine
19 that after the session today and drop a note to the
20 committee in writing.
21 **LADY HALLETT:** Thank you.
22 Sorry to interrupt, Mr Mills.
23 **MR MILLS:** Not at all, my Lady.
24 Mrs Paget can I finish with two questions about
25 DNACPR.

1 Can I ask you this. Does NHS Wales have any plans
2 to commission a wholesale review of DNACPR notices
3 issued during the pandemic which currently remain in
4 place in order to determine whether those notices are
5 appropriate?
6 A. So I'm not aware of any indication that a wholescale
7 review is required or requested. The DNACPR policy, as
8 I understand it, not being clinical, gives clear advice
9 and guidance to clinicians as to the regular updating
10 and checking with patients during normal clinical
11 contact around their status, whether anything has
12 changed, and gives advice on the updating of those as
13 needed.
14 Q. Thinking then about advance care planning perhaps more
15 widely can I ask you this. Has NHS Wales given
16 consideration to adopting the ReSPECT form in order to
17 ensure consistency with many parts of England and
18 Scotland?
19 A. My understanding is that the advance and future care
20 planning group that I mentioned earlier considers
21 regularly what has come out of the ReSPECT process, and
22 takes that into consideration when determining whether
23 further reviews are needed to our current policy.
24 My further understanding is that the Resuscitation
25 Council UK have indicated that they do not think the

1 form is a DNACPR form, but actually a form for recording
2 decisions.
3 The view of the group in Wales, which is made up
4 of lots of clinical professionals, is that the DNACPR
5 policy that we have in Wales, the advance care planning
6 form and all the other things that we have in place,
7 meet the needs of Wales, but clearly recognise that they
8 need to draw on the widest possible advice to make sure
9 that we keep up to date in terms of learning everywhere.
10 Q. Next, please, can we consider what NHS Wales has learnt
11 about the healthcare inequalities that were exacerbated
12 during the pandemic. First this, please. What work has
13 been performed in order to understand the unequal impact
14 of the pandemic in Wales?
15 A. So, you will know from my statement and evidence from
16 other colleagues that the focus of Welsh Government was
17 very much on the impact of the pandemic on black, Asian
18 and minority ethnic groups and a specific group was
19 established by the First Minister that then resulted in
20 two specific pieces of work, one looking at the
21 socioeconomic impact, particularly looking at structural
22 racism and the part that that continues to play in the
23 lives of ethnic minority people in Wales, and the other
24 one was the workforce risk assessment.
25 Both of those pieces of work, particularly the

1 socioeconomic subgroup, made a number of recommendations
2 for us in the Health and Social Services Group, I think
3 there are seven listed in my statement. Six of those
4 were enacted and completed at the time. There is
5 a seventh piece of work that is ongoing which relates to
6 racism and general issues related to the inequalities in
7 health that exist across Wales.
8 So pieces of work that have been done in relation
9 to that relate to trying to improve our data collection
10 systems which have been not helpful in understanding
11 those particular issues in relation to inequalities.
12 Q. Before you tell us how data collection has been
13 improved, can you help the Inquiry understand how
14 NHS Wales' understanding of these issues has been
15 limited by an absence of data?
16 A. So I think many of our data collection -- our
17 information systems, I'll use that word, many of our
18 information systems have not traditionally collected
19 ethnicity as a part of routine data collection, so we
20 have done some audit to look at where there are gaps and
21 we are trying to work, at the moment, to close those
22 gaps in a number of service areas. But, clearly, the
23 work around the all-Wales race equality plan in which
24 the NHS has clearly an important part to play is
25 fundamental to that.

1 And there are a number of service areas that we
2 focused on, particularly maternity programmes, and we've
3 just done some work on the inequalities and outcomes of
4 our cancer services, we've looked at childhood
5 vaccination, and clearly we've looked at Covid-19
6 vaccination from an equality point of view as well.
7 **Q.** You say work has been done to close the gaps.
8 **A.** Yes.
9 **Q.** Do I take it from that that the gaps have not yet been
10 closed?
11 **A.** No, they have not been closed. So of the -- we've
12 looked at, I think it was 43 different service areas in
13 terms of a whole range of indicators, and -- as you
14 might imagine, so age and sex is well represented in the
15 data systems but ethnicity probably represented in about
16 two-thirds of the data systems and we need to find a way
17 of reliably capturing ethnicity data and we are
18 exploring at the moment whether the work that we have
19 done to introduce an NHS Wales app in Wales might be
20 a reliable way of asking patients to submit ethnicity
21 data into our NHS system.
22 **Q.** Can you help us, when did problems with data in this
23 particular area come to the attention of those in senior
24 positions at NHS Wales?
25 **A.** So I think clearly the Covid-19 pandemic shone a light

1 on that, but prior to that there had been work
2 undertaken by Welsh Government, clearly before my time,
3 but I am aware of it, in relation to race equality
4 action, and that has continued.
5 I think what the pandemic has done has tried in
6 some way to speed up the work on that, create
7 a different imperative, one that everybody recognises,
8 and focus the attention on the things we can do to try
9 and tackle some of those issues.
10 **Q.** Speed up but, from what you say, if there were another
11 pandemic tomorrow, data collection on inequalities would
12 remain insufficient?
13 **A.** So it can -- it has improved because people are now much
14 more aware of the need to collect that level of data.
15 So new data systems are including it but clearly we have
16 to go back and redress the gaps in the data systems that
17 already exist. So there has been progress but
18 absolutely more progress is needed.
19 **Q.** New topic, please. The challenges the hospital estate
20 in Wales presented to the implementation of IPC
21 measures. Can we start in this way. Insofar as
22 generalisation is possible, it may well not be, are you
23 able to characterise the age of the hospital estate in
24 Wales?
25 **A.** I would describe it as very mixed. So in my own health

1 board -- or the last health board I worked in, we had
2 a brand new hospital that opened in 2020 that had 75%
3 single rooms and two hospitals that had opened in 2010
4 and 2012 with 100% single rooms and, you know, all the
5 things that go along aside that, in terms of
6 ventilation, et cetera.
7 And then we had one other hospital that was built
8 and became a hospital in the late 1890s, and everything
9 in between. So with variation, I would say, and very
10 mixed.
11 **Q.** Please can we return to the Glangwili General Hospital
12 statement.
13 That's INQ000475209, thank you.
14 I'd just like to run through some of these issues
15 that the statement sets out in respect of the hospital
16 estate acting as a barrier to the implementation of IPC
17 guidance.
18 And as we go through them, I might just ask you,
19 Mrs Paget, to help us with the extent to which these are
20 issues you recognise.
21 **A.** Okay.
22 **Q.** Wards and corridors being narrow and not having
23 air-conditioning or filtration systems?
24 **A.** Yes.
25 **Q.** A limited number of side rooms?

1 **A.** Definitely.
2 **Q.** Staffrooms too small for social distancing?
3 **A.** Yes.
4 **Q.** Next, please, back to the University Hospital of Wales.
5 That's INQ000480136.
6 Reading from paragraph 152:
7 "... no on-ward staff changing facilities.
8 "... limited control over entrances and exits for
9 staff, patients/visitors."
10 **A.** Yes.
11 **Q.** "... no formal ventilation apart from a very small
12 number of isolation rooms ..."
13 Such that:
14 "... only natural ventilation (open windows and
15 doors) was available, [making] it difficult to comply
16 with IPC guidance in [extreme weather]."
17 **A.** Yes.
18 **Q.** Recalling your time as CEO of Aneurin Bevan, are there
19 any other challenges that you might add to this list?
20 **A.** I think that's a comprehensive list, as far as I can
21 remember, yes.
22 **Q.** Can we next look at INQ000396261.
23 This is a ministerial briefing dated
24 15 November 2020, clearly before your time as CEO of
25 NHS Wales. If we can move to page 8, please. Under

1 "Bed spacing" we read this:
2 "The required 3.6m between beds has not been
3 fully implemented across Wales, due to the consequence
4 required of removing significant bed numbers ..."
5 Two examples are given: 98 bets would have had to
6 have been removed at the Royal Glamorgan Hospital, and
7 110 at the Prince of Wales. Do we see here the hospital
8 estate presenting health boards with a difficult choice,
9 between treating more patients or putting more space
10 between them?
11 A. I think it was a very difficult choice for people to
12 make. Clearly there were other choices to be made in
13 terms of securing other capacity outside the hospital,
14 so we did commission additional beds from the private
15 sector, and we were, in some parts of Wales, able to
16 secure step-down beds provided through
17 field hospital-type arrangements and secure beds
18 elsewhere. But, yes, it was a difficult choice, and
19 I know -- I see the paragraph refers to the use of
20 perspex screens between beds, why I know was provided in
21 parts of Wales as well. But, yes, but it was difficult.
22 Q. Looking to the future then, and appreciating that
23 a hospital estate cannot be transformed overnight, what
24 changes have been made or indeed will be made to the
25 hospital estate in Wales so that it can better implement

1 IPC measures in a future pandemic?
2 A. So this year and for the previous two years we have made
3 funding available to address some of the issues related
4 to ventilation in hospitals. So my understanding is
5 that an allocation of £34 million was made available in
6 2021, 22, and in the subsequent years, to address some
7 of those issues, advised by our engineering experts in
8 the shared services organisation that supports all
9 NHS Wales organisations.
10 Other things, including oxygen supply and water
11 systems, have also been included in that. So that's
12 one.
13 Clearly consideration needs to be given to any
14 new-build facilities, particularly hospitals, to
15 consider maximising the number of single rooms
16 available. It was an issue prior to the pandemic, in
17 terms of the isolation of patients with infections, and
18 clearly it was a considerable issue during the pandemic.
19 But I do know that the most recent hospitals built
20 clearly have got an increased number of single rooms,
21 which is a very positive feature, and I know has had
22 an important impact on hospital-acquired infections as
23 well.
24 Q. Next, please, can we consider concerns around the
25 communication of IPC guidance. Returning, I think for

1 the last time, to Glangwili.
2 That's INQ000475209.
3 At paragraph 92 we have the
4 observation that national guidance contradicted
5 professional guidance, and the example given here is
6 about whether FFP3 masks should be worn during CPR. And
7 we read in the final sentence:
8 "This was not an isolated incident."
9 Do you recall from your experience as CEO of
10 a health board that there were times when there was
11 a difference between national and professional guidance?
12 A. I do recall. I can't recall the specifics but I do
13 recall that there were occasions where there was
14 a contradiction in guidance received by the health
15 board.
16 Q. Do you have any reflections to share with the Inquiry on
17 how such contradictions might be avoided in the future?
18 A. I think it will be really important for UK, so the three
19 devolved administrations in UK government, to work
20 together, as they have been, in relation to the PPE
21 policies but also have very early engagement with the
22 professional bodies so that we are seen to be working
23 together and so that we don't get to the situation where
24 we have contradictory and different advice going out to
25 the NHS, one through professional organisations and one

1 through, you know, the government systems.
2 Q. If we look at the following paragraph, that's at 93, we
3 have this:
4 "A problem in Wales was that Public Health
5 England ... guidance was usually announced on
6 a Thursday, but guidance from Public Health Wales ...
7 the following afternoon (Friday). This caused
8 an unnecessary level of anxiety for staff aware,
9 through the media, of the PHE 'Thursday guidance' but
10 unsure whether or not these changes would be effective
11 in Wales until following day."
12 Can I ask you, was this issue of publication on
13 two separate days ever resolved during the pandemic?
14 A. I don't recall it being resolved but I do believe it
15 became less of an issue. So my recollection is -- from
16 my days in Aneurin Bevan, is at the very beginning of
17 the pandemic it was problematic, but actually, as soon
18 as we developed ways of working and understood that the
19 guidance for Wales would come out on a Friday, and as
20 there was more conversation between the NHS and
21 Public Health Wales and Welsh Government about what
22 might be in the new guidance when it came out on Friday,
23 it became less of an issue. But it was an issue at the
24 very beginning.
25 Q. Do you think that, in a future pandemic, English and

1 Welsh guidance ought to be issued on the same day?
2 A. That would be very helpful if that were possible.
3 Q. Next, please, the statement of University Hospital of
4 Wales, INQ000480136. We have this at paragraph 148:
5 "The fact that the national guidance changed so
6 often led to a lack of confidence in some of the
7 guidance."
8 Was this a sentiment you were aware of during your
9 time at Aneurin Bevan?
10 A. I was aware of the frequent changes in the guidance.
11 I don't recall any concerns being raised with me about
12 lack of confidence in the guidance but the frequent
13 changes were raised and I was aware of that.
14 Q. You were then the recipient of guidance?
15 A. Yes.
16 Q. You are now on the send side. In your view could the
17 communication of changes in national guidance during
18 a pandemic be improved, or are frequent changes
19 a necessary consequence of the rapid development in
20 understanding of a novel virus?
21 A. So I think at the very beginning it was, as you suggest,
22 that understanding of the virus in all its forms was
23 changing rapidly and therefore the guidance had to
24 change.
25 I think that did become easier as time went on,

1 and as I said, the most important thing is that there is
2 a regular dialogue between Public Health Wales, Welsh
3 Government and the service so that when the guidance
4 does arrive there are no surprises in it because the
5 communication of guidance and ensuring that everybody is
6 sighted on it is a phenomenal task for organisations
7 to do.
8 So the earlier we have notice, or organisations
9 have notice of what's likely to be in there, the earlier
10 they can start getting ready for the changes.
11 Q. Next, please, visiting restrictions.
12 Please can we look at INQ000469846.
13 This guidance was issued in November 2020. At
14 page 2, please, under "Background", reading from the
15 third paragraph we have this:
16 "... the Welsh Government reiterates that the
17 Guidance sets out the current baseline for visiting in
18 Wales during the pandemic."
19 It goes on in the next paragraph to allow
20 healthcare providers to depart from the guidance in
21 response to either rising or falling levels of
22 transmission in their local areas.
23 I realise this is a single piece of guidance
24 picked out, but can I ask you this. Is this broadly
25 reflective of the Welsh approach to visiting, that is to

1 allow local health boards flexibility in applying
2 visiting restrictions?
3 A. So my understanding was by this point in time,
4 November 2020, there was some clarity from Welsh
5 Government around guidance on more relaxation of the
6 restrictions that were put in in March 2020, so clearly
7 there had been learning from that and Welsh Government
8 were clearer about expectations in terms of maternity,
9 neonatal care, and obviously end-of-life care,
10 vulnerable adults, children et cetera.
11 But I think they recognise that the people who
12 were best placed to understand the balance of risk
13 between visiting and potential acquisition of Covid-19
14 through visiting and transmission were the individual
15 organisations, so health boards and trusts, and so
16 certainly by that point, I think, whilst encouragement
17 from Welsh Government was to ensure that we were
18 receptive to visiting and did whatever we could, the
19 decision-making around that assessment of risk was left
20 with organisations.
21 Q. At your paragraph 395, that's page 138, you refer to the
22 exceptionality clause which allowed local health boards
23 to agree to visiting requests outside of the guidance
24 where the benefit to the well-being of the patient or
25 visitor outweighed infection control risk.

1 Did this approach create inconsistency between
2 local health boards in allowing visits in certain
3 circumstances?
4 A. I think it may well have created a difference but I
5 think there would have been difference anyway because
6 even in my own health board we had different situations
7 in different hospitals at different times which we were
8 trying to reconcile, and so even in my own health board
9 there would have been differences. So absolutely across
10 Wales, yes.
11 Q. So that's different situations between different
12 hospitals.
13 A. Yes.
14 Q. Can we go to page 120 in your statement, paragraph 327.
15 You refer -- Mrs Paget, it's on the screen in front of
16 you if that's better.
17 A. Thank you, yes.
18 Q. You refer to -- and I'm in the first line -- other
19 exceptions, and these are in respect of visiting
20 restrictions in March 2020 in fact:
21 "Other exceptions were at the discretion of the
22 Ward Sister/Charge Nurse or manager with advice from
23 the [IPC] team."
24 Did this discretion risk the creation of
25 inconsistency within the same hospital because charge

1 nurse A might approve a visit on Monday, but charge
2 nurse B could reach a different view on the Friday and
3 refuse a visit?
4 **A.** On the same ward I would expect the same and similar
5 assessments but, clearly, a situation could change from
6 a Monday to a Friday. There could have been
7 an outbreak, there could have been something else that
8 impacted on the ward. But I think the issue was about
9 the justification of the decision and clearly the
10 infection prevention control team were giving consistent
11 advice across the organisation so they were in some ways
12 able to try and do that consistency check on behalf of
13 the health board.
14 **Q.** Can I ask you this then, please, about the approach to
15 visiting generally. In your view, should visiting
16 restrictions aim to be, as far as possible, consistent
17 nationally or do you endorse allowing for a more local
18 approach?
19 **A.** So I think there should be consistency around what we
20 deem to be essential visiting. As I mentioned, there
21 are some key groups that during -- based on our learning
22 during the early part of the pandemic, we would want to
23 have moved away from the very restrictive approach we
24 had in March to the more supportive approach we had
25 in November. I think it would be very difficult to have

1 an approach that was absolutely consistent at all times,
2 at all days, in all wards, in all hospitals, because
3 there will be variation in terms of the situation on
4 that ward at that time.
5 **Q.** You mention consistency for key groups.
6 **A.** Yes.
7 **Q.** Can I ask you to share some examples of who those key
8 groups might be.
9 **A.** So for maternity and neonatal services I would, based on
10 our learning and understanding, include partners from
11 antenatal care all the way through. Clearly end-of-life
12 care was seen as essential from the beginning.
13 Vulnerable adults, people who act as carers for others,
14 and clearly children, in terms of parental support, as
15 well.
16 **Q.** Final topic before perhaps we take a break, Mrs Paget.
17 Long Covid.
18 **A.** Okay.
19 **Q.** The Inquiry's Long Covid experts, Professors Brightling
20 and Evans summarise the Welsh approach to providing
21 Long Covid treatment as delivering these services not
22 through specialised clinics, as in England, but through
23 primary care. Is that a fair summary?
24 **A.** We -- our Long Covid service is an integrated,
25 multi-professional, community-focused rehab model, with

1 the ability to refer people to specialist clinics if
2 they need to -- or specialists, I should say, sorry, if
3 they need to.
4 **Q.** But it's right to say, is it not, that Wales has not
5 adopted the specialised Long Covid clinics that we see
6 in England; is that right?
7 **A.** That's correct.
8 **Q.** Professors Brightling and Evans told the Inquiry that
9 there is now evidence that specialised Long Covid
10 clinics are both clinically and cost effective. I'm not
11 asking you to comment on that. Can I instead ask this.
12 Since you became the CEO of NHS Wales, has consideration
13 been given to establishing specialised Long Covid
14 clinics?
15 **A.** There has been a constant evaluation of the model that
16 we have in Wales. It is compliant with NICE guidance.
17 It fits the geography and the spread of the services and
18 population of Wales. We are regularly reviewing the
19 evidence from research and trials as it becomes
20 available, and at the moment we haven't been required to
21 change our position but clearly, if new evidence comes
22 to light that is a material, then clearly we will
23 consider that in full.
24 **Q.** What particular support is offered by NHS Wales to
25 healthcare professionals with Long Covid in order to

1 assist them in returning to work?
2 **A.** So the Long Covid support for staff is organised and
3 available through our occupational health services. As
4 far as I am aware, there is no specific range of
5 services available consistently across Wales, but,
6 clearly, occupational health support is available to
7 everybody.
8 **Q.** Looking to the future then, what can you tell
9 the Inquiry about NHS Wales' plans to continue to treat
10 those suffering with Long Covid and research?
11 **A.** So Welsh Government has made ring-fenced money available
12 to ensure that people who need access to Long Covid care
13 and support are able to do so. That investment has
14 increased in the last financial year. We have been, as
15 I said, evaluating the current Long Covid service,
16 including a significant focus on what patients are
17 reporting as their positive outcomes. We will continue
18 to review that and continue our commitment to providing
19 support to Long Covid patients in Wales.
20 **Q.** Finally this then, please. Based on what has been
21 learnt about treating Long Covid, does NHS Wales have
22 a plan in place to make sure that in the event of
23 a future pandemic it is able to rapidly respond to the
24 long-term consequences of whatever that future pandemic
25 illness may be?

1 **A.** I do not think we have a plan at the moment but I do
2 think, as part of our ongoing pandemic preparedness, we
3 do need to think beforehand of what service models might
4 need to be put in place, either to respond to the
5 long-term impacts of a viral illness, if that's what it
6 were, or also to rapidly work with UK Government on
7 rapid research into what might help respond to any
8 underlying health conditions caused by whatever the
9 nature of any virus might be.
10 **MR MILLS:** My Lady, would that be a convenient moment?
11 **LADY HALLETT:** Of course.
12 I shall return at 3.10.
13 **(2.54 pm)**
14 **(A short break)**
15 **(3.10 pm)**
16 **LADY HALLETT:** Mr Mills.
17 **MR MILLS:** My Lady.
18 Mrs Paget, turning to lessons learned and
19 recommendations. At annex A of your statement,
20 referenced INQ000485240, you set out the reviews that
21 have been performed in Wales into matters within this
22 module's scope. To summarise, there have been a number
23 of reviews conducted by different organisations into
24 distinct areas of the pandemic response; is that a fair
25 summary?

1 **A.** That's correct.
2 **Q.** So, to give some examples, we have the Equality, Local
3 Government and Communities Committee, reporting on
4 inequalities?
5 **A.** Mm-hmm.
6 **Q.** We have Audit Wales performing the review into
7 procurement and supply of PPE, and we have the
8 Healthcare Inspectorate Wales producing a review into
9 how healthcare services maintained patient safety during
10 the pandemic.
11 **A.** Yes.
12 **Q.** NHS Wales has not, however, produced a single
13 overarching report into the pandemic response in Wales
14 like the one produced by NHS England in 2023; is that
15 right?
16 **A.** That's correct.
17 **Q.** Do you consider that NHS Wales has a duty to produce
18 a single comprehensive report to enable it to identify
19 and reflect on the lessons to be learnt from its
20 pandemic response?
21 **A.** My view is that there have been, as you say -- you've
22 listed some, but there have been more, reports into how
23 both Welsh Government and NHS Wales managed the response
24 to the pandemic. There was a formal review undertaken
25 by the Health and Social Services Group that included

1 input from NHS organisations and social care into the
2 response that was done in August/September 2020, and
3 then again in 2021, that made a number of
4 recommendations around our lessons learnt.
5 We have followed those up and closed off now all
6 the recommendations. So everything has been complete.
7 The last outstanding recommendation was the
8 establishment of the NHS Wales Executive, which has now
9 been established.
10 **Q.** I'll ask you about that in a moment, if I may, Mrs Paget
11 but can I ask you this. Are you confident that the
12 various patchwork of reviews performed has identified,
13 together, all of the lessons to be learnt from the
14 pandemic response in Wales?
15 **A.** So I am confident that it has. I am confident that
16 organisations have learnt individually what we are now
17 going to be doing. And I know you want me to ask me
18 about the NHS Wales Executive, but, just in response to
19 this question, we are now going to be reviewing all of
20 the plans that NHS organisations have updated, following
21 their own learning lessons and reflections. We will
22 review those both individually with organisations and
23 collectively through the NHS Executive, and if there are
24 any further learning or lessons that we need to address
25 then we will do so.

1 Also to say that in the last four weeks I did
2 bring the chief executives of NHS Wales together, along
3 with some of their senior team, plus the team that
4 I support in Welsh Government, to review the Module 1
5 report, but also that did give us an opportunity to
6 gather some further reflections from organisations as
7 well on some key things. So that does exist. If you
8 would like me to submit that to the Inquiry, I could do
9 that.
10 **Q.** You have, as we've moved through this afternoon's
11 topics, shared lessons and recommendations. Can I ask
12 you about lessons in respect of some discrete matters,
13 please.
14 First, two matters that Dr Goodall, your
15 predecessor, was asked about this morning who said you
16 may well be better placed to answer. First, what, if
17 any, lessons have been learnt about the use of field
18 hospitals, please?
19 **A.** The last review of field hospitals and lessons learnt
20 was done in March 21. I am not aware of any subsequent
21 reviews or lessons learnt since Dr Goodall left the role
22 and I took over.
23 **Q.** Are you able to share with the Inquiry any of those
24 lessons?
25 **A.** I can make them available. I don't have them with me

1 but I can do that.
2 Q. He was also asked about bereavement services --
3 A. Yes.
4 Q. -- by reference to the report produced by the nosocomial
5 Covid-19 programme in March 2023, which identified that
6 bereavement services -- I apologise -- final report
7 produced in August 2024, in fact -- identifying that
8 bereavement services should be proactively signposted
9 and offered to all families experiencing grief following
10 the loss of a loved one.
11 Help us, please, how is the NHS currently ensuring
12 that such services are being proactively signposted and
13 offered?
14 A. So during and since the pandemic a national bereavement
15 pathway has been developed by the NHS in Wales. It's
16 a consistent policy and pathway that all organisations
17 are required to implement. Every organisation now has
18 bereavement services in place and the executive teams of
19 those organisations are charged with ensuring that they
20 monitor, evaluate, and get feedback on the effectiveness
21 of those services.
22 Also, you will know that, as you mentioned, the
23 nosocomial transition programme, end of programme report
24 also makes specific comments on this and we will be --
25 I will be receiving a quarterly update on the

1 implementation of the recommendations in that report to
2 ensure that that is being followed up.
3 Q. Aside from a quarterly update, what is the NHS Wales
4 doing to ensure that these services are being changed in
5 accordance with the report?
6 A. So the report -- the pathway is there. There is
7 a requirement to implement it. Additional resources
8 have been provided to organisations to make sure it
9 happens and, as I've said, organisations themselves
10 should be ensuring that that pathway is followed and
11 they regularly review that it is, and they will then
12 report in to us through that mechanism, as I've just
13 mentioned, with quarterly reports coming to me.
14 Q. There have been several reviews into the supply of
15 adequate PPE during the pandemic. I won't ask you about
16 each of those reviews individually but perhaps this,
17 please. Can you share with the Inquiry the key lessons
18 that have been learnt in respect of ensuring an adequate
19 supply of PPE?
20 A. So my general reflections on PPE supply based on my
21 experience in Aneurin Bevan was that Wales managed to
22 ensure a good supply through procurement arrangements
23 put in place by NHS Wales shared services. I don't
24 recall any difficulty around the availability of PPE
25 during the pandemic but clearly the important thing is

1 that we are really clear at the beginning of the roles
2 and responsibilities of UK versus devolved
3 administrations. In Wales it was agreed, or across the
4 UK it was agreed the devolved administrations would
5 procure and supply their own PPE during the pandemic and
6 once that decision was made I think the system was quite
7 effective. So the most important thing is we're really
8 clear who is doing what.
9 Q. Staff well-being, please. What has NHS Wales learnt
10 about the effectiveness of measures taken to support the
11 mental health of staff working during a pandemic?
12 A. So I think the pandemic shone a light on something that
13 was already receiving attention but actually the impact
14 on staff well-being from working during the pandemic has
15 been immense and so the investment that's been made in
16 additional services, both at a local organisational
17 level and obviously on an across-Wales level has been
18 well received, well evaluated, well supported, and our
19 staff unions are very positive about both the impact
20 it's had and obviously the need to continue that.
21 I think alongside that, as well as the
22 psychological well-being of staff, it's really important
23 that we continue to develop our occupational health
24 services to make sure that we're able to support staff
25 with the physical impacts but also clearly Long Covid as

1 we've discussed as well. So there is a balance to be
2 struck not only around the psychological well-being
3 support but the need to make sure our occupational
4 health services are well resourced as well.
5 Q. Can you tell the Inquiry, please, about the structural
6 changes, then, that have been made to ensure that
7 NHS Wales can be more agile in its response to a future
8 pandemic?
9 A. So there have been changes made within the Welsh
10 Government group that I'm the DG of. We have created
11 a public health directorate with additional resource and
12 focus to ensure that we're continuing not only to focus
13 on our pandemic preparations but also responding to
14 individual issues as they arise, as they have even since
15 the pandemic.
16 We have also embedded learning from the Technical
17 Advisory Cell, so making sure that we're able to develop
18 our own modelling and reviews of evidence and linked
19 through to research as well. So we have a small core of
20 people now who support us with modelling data, most
21 recently modelling what this winter might look like in
22 terms of infectious disease. We've also created
23 an ongoing commitment with Swansea University to help
24 with that modelling data as well.
25 We've provided additional support for the CMO,

1 with a second deputy CMO for public health, and we have
2 outside of government created an NHS Executive by
3 bringing together functions that already existed in
4 NHS Wales to create a critical mass of individuals who
5 can support us to deliver on ministers' priorities and
6 policies and ensure that the policy objectives of Welsh
7 Government are consistently implemented across
8 NHS Wales.
9 As part of that I would say we have created a new
10 team within the executive which will have responsibility
11 for emergency planning, preparedness and response and
12 will co-ordinate and bring together and provide
13 assurance on the plans of individual NHS organisations
14 to make sure that we share good practice, quality assure
15 the plans, but also support the testing of those plans
16 on a frequent basis.
17 **Q.** Have any of those plans yet been tested?
18 **A.** There was a table top exercise done a couple of months
19 ago in relation to some of the plans and also in the
20 preparedness of Mpox there have been further testing
21 reviews of isolation rooms and other things which are
22 related to preparedness for that.
23 **Q.** Finally, then, are there any lessons which I have not
24 yet invited you to comment on that you would like to
25 share with the Inquiry?

1 **A.** I think we've covered most of them during my evidence,
2 thank you. The only other one that I would probably add
3 in relation to infection prevention control, as well as
4 ongoing investment which I've mentioned, and single
5 rooms which I have mentioned, is to make sure that we
6 can agree a core specification for an optimal infection
7 prevention control service and team because I was very
8 struck during the pandemic that although we'd invested
9 considerably in our infection prevention and control
10 team they were stretched considerably, incredibly busy,
11 worked incredibly hard but there is something to make
12 sure that we're all working to a consistent standard.
13 And other than that, we've picked up visiting,
14 we've picked up palliative care, and all the other
15 things I was going to mention. So thank you, Mr Mills.
16 **Q.** Just finally please on the core specification. Can you
17 help us, perhaps by way of example, of what that might
18 include?
19 **A.** So I think it might include the competencies and
20 capabilities that you might need in your infection
21 prevention and control team and service, what the role
22 of a consultant in infection prevention -- consultant
23 nurse in infection prevention control might look like,
24 their job content, and what the make-up of the team
25 might be, and what resources do they need access to in

1 terms of training, development and ongoing support.
2 **MR MILLS:** Mrs Paget, thank you.
3 My Lady, that's all I ask.
4 **LADY HALLETT:** Thank you.
5 Ms Waddoup.
6 Over that way, Mrs Paget.
7 **Questions from MS WADDOUP**
8 **MS WADDOUP:** Thank you, my Lady.
9 Good afternoon, Mrs Paget. I represent Clinically
10 Vulnerable Families and I have some questions for you,
11 please, regarding safe access to healthcare for members
12 of this group.
13 Firstly, was any specific consideration given to
14 clinically vulnerable people who needed to access
15 healthcare during the pandemic and, importantly, how
16 they could do so safely?
17 **A.** So it's difficult to know on what basis you're asking
18 me. So, as the Welsh Government -- I can't answer that
19 question for Welsh Government. Clearly I wasn't in
20 Welsh Government then. But from a health board point of
21 view, my reflection is that we worked really hard to
22 make sure that people could have safe access to care,
23 that we had a variety of options available to people,
24 from virtual, face-to-face to telephone access, but also
25 if people needed to come into our hospitals, that we

1 would arrange for them to have safe routes into hospital
2 and be cared for appropriately when they arrived with
3 us.
4 **Q.** So, perhaps just with your health board hat on, what do
5 you mean, sorry, when they arrived in hospital --
6 **A.** So if they were coming --
7 **Q.** -- what were the specific measures?
8 **A.** -- to an outpatient's appointment, for example, making
9 sure that they had a safe place to wait, that they
10 didn't wait too long, that they hopefully went straight
11 into the clinic room, they were seen quickly and
12 supported. If they needed a diagnostic test, that that
13 was done as quickly as possible. And they were
14 supported to get what they needed in terms of medical
15 attention quickly and then could leave.
16 **Q.** Thank you.
17 Moving then to the here and now. The Inquiry has
18 heard evidence from IPC expert, Dr Warne, that there is
19 an ongoing need to consider how clinically vulnerable
20 people can safely access healthcare settings, including
21 hospitals.
22 Do you agree with Dr Warne with that, and if so
23 what if any steps are being taken now to ensure this can
24 happen?
25 **A.** So I would agree that we should always ensure that

1 patients and family ability to access safe care is
2 a priority. I'm not aware of any specific things that
3 are happening at the moment to support that but clearly
4 if our staff are aware that somebody is clinically
5 vulnerable or extremely clinically vulnerable they will
6 do their best to support them in whichever way possible.
7 **Q.** Thank you.
8 Next, I'd like to ask you, if I may, about the
9 potential role of carbon dioxide monitors. And at
10 paragraph 310, which is page 114, of your statement if
11 that assists.
12 You describe there a letter sent by the Minister
13 for Health to the Royal College of Nursing after the
14 College has asked the Welsh Government to, amongst other
15 things, consider providing CO2 monitors in healthcare
16 settings. This is in March 2022.
17 The minister's letter indicated that there were no
18 plans at that time to do so because, and I quote from
19 the letter, "different air change conditions are
20 required in individual settings".
21 Are you able to explain that further and to help
22 us understand why a policy of providing CO2 monitors
23 wasn't adopted within the NHS Wales estate, given that
24 we know that they're a reliable measure of how well
25 ventilated a confined space is and, therefore, give us

1 an indication of the likely Covid-19 transmission risk?
2 **A.** Apologies, I can't add any more clarity to what's in my
3 statement.
4 **Q.** Thank you.
5 Final question then, if I may, concerning
6 inequalities. At paragraph 755 of your statement,
7 that's page 279, you indicate that the Welsh Government
8 considered, amongst other groups, the clinically
9 vulnerable when addressing changes to the delivery of
10 healthcare services and also when giving input and
11 advice and policies in the healthcare context.
12 Are you able to help us with any specific examples
13 of how the clinically vulnerable were considered in
14 these contexts and are you aware of current policy
15 continues to be assessed for potential impacts on the
16 clinically vulnerable cohort?
17 **A.** So I am aware that our impact assessments take a wide
18 range of considerations into account. Particularly
19 I recall the document that was published around the
20 pandemic, "Next steps", and the risk assessment in there
21 makes specific reference to clinically vulnerable
22 individuals as being a key consideration. So my view of
23 the impact assessments that I've seen since I've been in
24 Welsh Government is they take quite a wide view of
25 impacts, disability, race, et cetera, but where there

1 are significant impact on particular groups, they will
2 draw that out.
3 **MS WADDOUP:** Thank you.
4 Thank you, my Lady, those are my questions.
5 **LADY HALLETT:** Thank you very much, Ms Waddoup.
6 Mr Wagner.
7 Sitting next to her.
8 **Questions from MR WAGNER**
9 **MR WAGNER:** Good afternoon. I ask questions on behalf
10 13 Pregnancy, Baby and Parenting Organisations.
11 I want to ask you, first, about visiting guidance.
12 In the visiting guidance that was brought into force
13 in May 2022, a nominated partner was recognised as
14 a partner in care. Do you agree this was a recognition
15 of the essential care that pregnant people receive from
16 their partners during and around pregnancy?
17 **A.** I do indeed.
18 **Q.** And do you agree that this recognition came too late?
19 **A.** I can understand why the initial restrictions on
20 visiting were as they were because people were very
21 worried about safety of everybody, but I think the right
22 decision was made to adjust the guidelines later to
23 ensure that partners or close family members were able
24 to support somebody through all stages of their
25 pregnancy.

1 **Q.** I'm sorry, that wasn't exactly the question I was
2 asking, I was asking if the recognition that these
3 weren't just visitors, they were partners in care, which
4 only was added to the guidance in May 2022, two years --
5 more than two years after the pandemic began. Do you
6 agree that that recognition came too late?
7 **A.** I agree that it could and should have been recognised
8 earlier.
9 **Q.** You said earlier in response to a question you were
10 asked about visiting guidance that:
11 "... for maternity and neonatal services I would,
12 based on our learning and understanding, include
13 partners from antenatal care ..."
14 I think probably "in antenatal care" --
15 **A.** Yes.
16 **Q.** "... all the way through."
17 So just to clarify, your view is that partners
18 should have been permitted to access antenatal care, so
19 ultrasound appointments, that sort of thing, throughout
20 the pandemic?
21 **A.** I mean, this is -- it's a personal view. I think
22 partners play a really important part in supporting the
23 delivery of care so I would absolutely support that.
24 **Q.** And they're a partner is care is what you agreed?
25 **A.** Absolutely.

1 **Q.** Neonatal visiting, it wasn't until May 2022 that
2 directive guidance that both parents would be able to
3 visit their baby on a neonatal ward together was
4 introduced. Were you aware that Wales was the last of
5 the four nations to direct hospitals to allow both
6 parents to have unrestricted access to their babies on
7 neonatal wards?
8 **A.** I was not aware.
9 **Q.** Can you explain the reasons why it took until May 2022,
10 over two years, to direct hospitals to allow that?
11 **A.** I don't think I can, to be honest. I know that the --
12 colleagues were reviewing visiting principles, and took
13 a very broad view with colleagues from the NHS around
14 an updating of the visiting guidance and developed
15 principles. Whether that then -- that changed to the
16 neonatal visiting came as a result of that, I'm not sure
17 but I wasn't aware and I don't know why it took so long.
18 **Q.** Do you consider that it may have been there was a lack
19 of priority being given to women's and maternity-related
20 care generally, that led to that delay?
21 **A.** I don't accept that.
22 **Q.** Do you accept, on reflection, that neonatal visiting
23 restrictions ought to have been addressed earlier than
24 May 2022?
25 **A.** I think that given that we were reviewing visiting

1 restrictions from a wide range of perspectives, I am
2 surprised that it took that long to develop those
3 changes in guidance for neonatal care.
4 **Q.** And do you think that if that partner in care change had
5 been made earlier, so recognising partners as something
6 more than a visitor, do you think that potentially would
7 have flowed through to earlier changes in the guidance
8 for visitors to those kind of services?
9 **A.** What I can't comment on is, although the guidance
10 changed in, I think you said May 2022, I'm not sure what
11 the practice was at that time, so it could have been
12 that practice had already changed and the guidance was
13 changing to keep up with practice because clearly in
14 units across Wales we had given the ability for health
15 boards, ward managers, et cetera, charge nurses, to make
16 decisions around visiting so it could be that actually
17 practice had already changed and the guidelines were
18 just changed to keep up with that.
19 **Q.** Do you have any record or did you take any -- did you do
20 any research to see what individual decisions were being
21 taken up till then?
22 **A.** I haven't personally but I would be confident that the
23 group that oversaw the changes to the visiting guidance
24 and the principles would have been working very closely
25 with NHS colleagues and would be well aware of what was

1 happening in practice at that time.
2 **MR WAGNER:** Thank you.
3 **LADY HALLETT:** Thank you, Mr Wagner.
4 Ms Hannett.
5 Now, Ms Hannett is over there, so please make sure
6 your answers go into the microphone.
7 **Questions from MS HANNETT KC**
8 **MS HANNETT:** Mrs Paget, I ask questions on behalf of the
9 Long Covid groups.
10 I'm going to ask you first about Long Covid
11 services. In the July 2022 Adferiad Long Covid service
12 report, feedback called for more medical diagnosis and
13 testing to be available to facilitate treatment and not
14 just rehabilitation. Service users were also still
15 calling for dedicated consultant-led clinics reflecting
16 similar requests in earlier national evaluations and
17 meetings between Long Covid Wales and the Welsh
18 Government and a petition to the Welsh Parliament.
19 You said in your evidence just now that Wales is
20 not required to change its position on the provision of
21 Long Covid services from the current model to
22 a specialist Long Covid clinic model. But given the
23 consistently large number of Long Covid patients
24 reporting that the current system is not working for
25 them, why have you not done so?

1 **A.** So I think, as I said, the model that we have in Wales
2 has been designed by senior leaders, clinicians and
3 service providers in Wales. It's consistent with NICE
4 guidance. It's a rehabilitative community-based model
5 that enables people to be referred into specialist
6 services if their condition requires it. There have
7 been four CEDAR evaluations of the service, the last one
8 being on 14 February '23, and although there are still
9 concerns around the service, they do relate to things
10 such as a medical diagnosis which was picked up in the
11 early part of the evaluation, that the rehabilitation
12 was not always tailored around their own personal needs,
13 appointments not being at convenient times and a slow
14 referral process.
15 So I think that as far as the evaluations are
16 concerned there's still a very positive feedback from
17 people. Clearly there are improvements to be made. As
18 a result of the feedback from the most recent studies,
19 additional resources were made available to health
20 boards from Welsh Government to make the improvements in
21 relation to that feedback and we have just received the
22 health board's most recent evaluation of their local
23 services which are currently being reviewed.
24 But as I said earlier, if NICE guidance changed or
25 if the evidence becomes very strong that the model

1 should change in Wales then clearly that will be
2 considered.
3 Q. Ms Paget, what I'm suggesting is that the Inquiry's
4 Long Covid experts, Professors Brightling and Evans,
5 gave evidence that the Welsh model has a number of
6 distinct disadvantages, including disconnect with
7 secondary care and also implications for training as
8 there's not a group of specialists. It's also the case
9 that three other nations adopt the Long Covid specific
10 clinic model. So why is, in the light of Brightling
11 Evans' evidence and the approach of the other three
12 nations, why is Wales the outlier?
13 A. As I have said before, and I will continue to say, as
14 the evidence changes we will continue to review the
15 model. Clearly, the geography of Wales is quite
16 different. Our population of 3 million people is spread
17 across, you know, I don't know, 8,000 square miles
18 trying to deliver centralised hospital based services,
19 specialist clinics that are accessible for people so
20 that they don't -- aren't required to travel long
21 distances to get to those services is a consideration
22 but clearly we'll keep the situation under review.
23 Q. Can I turn to children and young people with Long Covid.
24 Again, there's no dedicated Long Covid clinics or
25 services for children and young people with Long Covid

1 in Wales. In your letter to Andrew Goodall dated
2 6 May 2022 you acknowledge that there are a number of
3 children presenting with Long Covid in Wales, and that
4 some have very significant needs. You added that, as in
5 the situation with adults with Long Covid, children with
6 the condition are being treated close to home wherever
7 possible rather than being seen in specialist clinics,
8 as they might be in England.
9 Again, the Long Covid experts have said at
10 paragraph 84 of their report that regions with lower
11 rates of Covid-19 and fewer patients with Long Covid are
12 likely to have inexperienced healthcare professionals,
13 which supports the need for a virtual, multidisciplinary
14 team, delivered by the post Long Covid children and
15 people hubs. Would you agree with the Long Covid
16 experts that creating a virtual, multidisciplinary team
17 to deliver specialised care from Long Covid hubs for
18 children and young people with Long Covid is
19 advantageous, given that few paediatricians will have
20 the knowledge and expertise to deliver specialist care?
21 And just to answer the geography point, it is
22 a virtual hub as opposed to one that they would have to
23 travel to.
24 A. So we've got a Long Covid pathway for children that was
25 developed by Aneurin Bevan University Health Board that

1 has been shared with all health boards. We have done
2 awareness raising and sessions with them to draw out how
3 that model can be implemented.
4 As I've said, we've just had the reports in from
5 all the health boards around both adult and children
6 services related to Long Covid so I'd be interested in
7 seeing our own evaluation of that and views on the
8 services before considering that further.
9 Q. And as part of that evaluation, would you recommend that
10 they consider the evidence that's been provided to this
11 Inquiry by Professors Brightling and Evans?
12 A. Absolutely. And only recently our strategic evidence
13 and analysis team did a review of Long Covid services
14 and evidence. I think it was August this year. They
15 will do that on a regular basis. That evidence supports
16 the group that are developing and designing the services
17 in Wales, and that will continue. So any new evidence
18 that comes to light will absolutely be taken into
19 account in terms of reviewing the service on an ongoing
20 basis.
21 Q. Finally, final topic if I may, Mrs Paget, that's data
22 and Long Covid. In the January 2022 Adferiad programme
23 report, that stated that there were difficulties
24 robustly collecting the data that would have been needed
25 due to changes in service provided, lack of

1 Long Covid-specific clinical coding, and the importance
2 of community services that would not be captured in
3 databases such as the SAIL Databank.
4 Question: in Wales, was there a difficulty in
5 relying on data drawn from the coding of Long Covid in
6 GP practices?
7 A. So I think at the beginning my understanding is --
8 clearly I wasn't in Welsh Government then, so I'm
9 speaking from what I've been told as opposed to what my
10 personal experience has been -- I understand that there
11 was some concern that the GP systems weren't recording
12 all the cases of Long Covid but clearly we've been doing
13 a lot awareness raising. There is now a dedicated
14 health pathway in Wales that is consistently applied
15 across Wales. So the quality of the data should be
16 improving.
17 But again, as part of this review of the reports
18 that have just come in from the NHS, we will also be
19 looking at the number that are recorded on the GP
20 systems as well.
21 Q. Given that documented issue with the coding of
22 Long Covid, how can the Welsh Government be confident
23 that it's able to assess if all of the people with
24 Long Covid who need services are able to access them?
25 A. So I think that's a difficult question to answer.

1 Clearly we are promoting that the services are
2 available. The GPs are aware that the pathway is there
3 as people engage with them. And clearly not everybody
4 who has Long Covid symptoms has wanted to seek help, but
5 it is incumbent on us to make sure that we continue to
6 raise awareness about the availability of services so
7 that they are -- so we are encouraging people to come
8 forward.
9 So I think it's about keep the awareness raising,
10 ensure that GPs are familiar with the pathway and the
11 services are available, and that access to the services
12 is timely for individuals and that people are getting
13 the services that they need.
14 And one of the things that we have done is made
15 sure that we include in our ongoing evaluation
16 patient-reported outcome measures, so we are absolutely
17 capturing the benefit that patients have received from
18 the services that they've had.
19 **Q.** Final question, if I may, Mrs Paget.
20 ONS is no longer recording data on the prevalence
21 and severity of Long Covid in Wales. Can you just
22 explain -- you may well have covered this in your last
23 answer but can you just explain whether Wales maintains
24 any current surveillance or data gathering of prevalence
25 and severity of Long Covid outside of the clinical

1 coding and access to Long Covid services?
2 **A.** My understanding is that we don't, but I would have to
3 double-check on that.
4 **MS HANNETT:** Thank you, I'm grateful.
5 Thank you, my Lady.
6 Thank you, Mrs Paget.
7 **LADY HALLETT:** Thank you, Ms Hannett.
8 Mr Thomas.
9 Mr Thomas is behind you.
10 **Questions from PROFESSOR THOMAS KC**
11 **PROFESSOR THOMAS:** Good afternoon, Mrs Paget.
12 I'm representing FEMHO. That's the Federation of
13 Ethnic Minority Healthcare Organisations.
14 In paragraph 429 of your statement, the advisory
15 group outline recommendations for mitigating risks to
16 black, Asian and minority ethnic healthcare workers,
17 such as ensuring access to appropriate PPE and
18 conducting regular risk assessments.
19 I'm sure you remember that.
20 **A.** I do.
21 **Q.** Can you provide specific examples of how NHS Wales
22 ensured that these recommendations were practically
23 implemented across different NHS Wales trusts.
24 **A.** So I wasn't working in Welsh Government then so I can
25 comment from a perspective from Aneurin Bevan Health

1 Board, if that's acceptable.
2 So there were, as I said earlier, seven
3 recommendations that were directed towards the NHS, one
4 of them, relating to unfair or illegal discrimination
5 and anti-oppressive practices, is subject to ongoing
6 work through the Anti-racist Wales Action Plan, which
7 I can expand on further if you need me to.
8 The first few recommendations related to the
9 dissemination of the risk assessment tool and
10 encouraging of its use. And I recall very clearly that
11 in Aneurin Bevan we clearly developed our own version of
12 that risk assessment tool quite early and made it
13 available to Welsh Government.
14 So by the time the Welsh Government one arrived
15 with us, we'd already done a significant amount of work,
16 not only through our staff group, so direct line
17 management, but working with our staff and trade unions
18 to actually make everybody familiar with the tool,
19 highlight how important it was for it to be used, and
20 made copies available electronically and on paper and
21 promoted the use of it through our regular
22 communications, which were going out into the
23 organisation probably every day after our gold meeting.
24 And from a Welsh Government point of view,
25 I understand from colleagues that they did review it

1 regularly as evidence changed around the pandemic and
2 its impact. I can't tell you how many times it was
3 changed but I know it was updated.
4 **Q.** Well, in fact I think you've touched upon my second
5 question. If you want to expand upon it -- I'll ask the
6 question in any event, but I think you might have
7 touched upon it, which is, what were the monitoring
8 mechanisms that were established to track the
9 implementations of these recommendations and how were
10 these results reported and evaluated across NHS Wales,
11 and the various trusts?
12 **A.** So I can't recall -- because I wasn't in Welsh
13 Government then, I can't recall how it was collated
14 across Wales. I can recall locally, in the health board
15 we followed, at both the dissemination and uptake of the
16 tool, clearly working with line managers to make sure
17 that people who had high scores triggered by the tool
18 were offered appropriate support. That we had
19 stockpiles of PPE available. We used the support of the
20 military to ensure that the PPE was available as close
21 to our staff as possible, so we ended up putting PPE
22 stores on all hospital sites and making them available
23 close to primary and community services.
24 Clearly, we established a BAME network working
25 with our trade unions, and we continue to support people

1 to raise concerns about -- concerns about racism or any
2 issues related to oppressive practices within the NHS.
3 **Q.** Thank you.
4 Let me move on. In your statement you refer to
5 the work of the socioeconomic subgroup, which published
6 its recommendations on 25 June 2020, and just to remind
7 you the subgroup report made 37 recommendations to
8 address inequalities for ethnic minority communities
9 during the pandemic.
10 Can you provide us with an update on the specific
11 actions taken by NHS Wales to improve the quality of
12 ethnicity data collection as recommended by the subgroup
13 and how this has impacted health outcomes.
14 **A.** So one of the key things that have happened in the last
15 12 months is that we have developed the Workforce Race
16 Equality Standard and we have collected data from
17 a variety of sources to provide out to NHS organisations
18 information around the 12 standards that are in the race
19 equality standard. We've collected the data from
20 a variety of sources, put it together and created
21 standard reporting mechanisms and reports out to
22 organisations. We did also publish a national report
23 that is available on the Welsh Government website.
24 In terms of following up, so as well as giving the
25 report and the data out to organisations, colleagues in

1 my team have met with every NHS organisation to go
2 through the outcome of that report, the recommendations
3 that are in there, but also, as part of my role in Welsh
4 Government, we have also been looking at things that we
5 can do on a national basis to support the NHS in Wales.
6 So things like how can we ensure that we have more
7 diverse membership of NHS boards, running a shadowing
8 programme et cetera, et cetera. So there's been a huge
9 amount of activity in the last 12 months.
10 **Q.** Again, I think you may have just overlapped a little bit
11 into my next question, which is fine. If you want to
12 develop it, please do. I was going to ask, how has that
13 implementation of these recommendations been evaluated?
14 **A.** The Workforce Race Equality Standard?
15 **Q.** Yes.
16 **A.** So, the reports went out in September -- sorry, the
17 reports went out in August. The meetings with all --
18 organisations will be have been held during September,
19 and I chair an equality diversity inclusion board and at
20 the next meeting we'll get feedback from the receipt of
21 those, the feedback and next steps in terms of actions
22 individual organisations are taking.
23 If I could also add that for the chairs of all NHS
24 organisations, they have a specific objective from the
25 Cabinet Secretary to ensure that they are paying due

1 regard to that information and all the actions in the
2 Anti-racist Wales Action Plan, and they will be required
3 to update the Cabinet Secretary at their own personal
4 appraisals as to the progress their organisation has
5 made.
6 **Q.** Thank you.
7 Can you provide examples of specific health
8 outcomes that have improved for ethnic minority
9 communities as a result of these actions?
10 **A.** So these are -- the ones that I've been talking about
11 are particularly related to workforce race equality.
12 One of the areas that we've focused on actually relates
13 to maternity care and we've been working with the
14 universities to try to increase the diversity of people
15 who are coming forward for maternity training, so that
16 our maternity/midwifery services are better
17 representative of the communities that we serve. That
18 is still work in progress but it's been a really
19 important first area of work that we have ventured into
20 in terms of trying to ensure that services in Wales
21 better represent the people that they are serving.
22 **Q.** This leads me on to my next area which is the advisory
23 group made -- recommended immediate action to improve
24 ethnicity data collection quality, yes?
25 **A.** Yes.

1 **Q.** Can you just share with the Inquiry what specific
2 challenges NHS Wales faced in achieving this and how did
3 this impact your ability to address health inequalities
4 for ethnic minority communities during the pandemic?
5 **A.** So in relation to workforce, what we have identified is
6 quite a significant number of staff, particularly at
7 a senior level have not declared their ethnicity on our
8 electronic staff recording system, so about 10% of
9 staff. So we are working with organisations as well as
10 responding to the findings of that report to actually
11 ensure and encourage staff to make sure that their data
12 is recorded on our system because that will help.
13 In relation to the broader data issues, I think as
14 I said in response to a question from Mr Mills, clearly
15 data capture on some of our NHS patient systems is
16 definitely not where we need it to be. We have taken
17 some steps to improve it and new data systems, new
18 informations such as the Covid vaccination system
19 clearly captures ethnicity data but I think I would have
20 to say it's work in progress but it is most definitely
21 receiving attention as part of this work.
22 **Q.** I think you've covered my next question so let me move
23 on to the question after that.
24 One of the subgroup's key recommendations was to
25 enhance healthcare access for ethnic minorities. Can

1 you explain the strategies that NHS Wales employed to
2 ensure equitable access to healthcare, including
3 culturally competent mental health services?
4 **A.** So I think -- we've got a strategic programme for mental
5 health and as part of their work they have a number of
6 areas that they're looking at but ensuring that --
7 again, it goes back to the diversity of the workforce
8 but also the training that is available to people in
9 order to ensure that they're able to appropriately
10 support and develop the care of individuals that they
11 come into contact with.
12 So as I said, there are a number of areas, mental
13 health, maternity. We've been looking at --
14 specifically at areas around cancer services and
15 inequalities in relation to cancer and cancer screening
16 and there are a number of other areas as well.
17 **Q.** The report mentions black, Asian, and minority ethnic
18 staff network group as platforms for ethnic minority
19 staff to voice their concerns. Can I ask you this. How
20 effective have these groups been in providing insights
21 into inequalities within the healthcare system and what
22 measurable improvements have resulted from their input?
23 **A.** I can't comment on measurable improvements but clearly
24 what we will want to see through the publication of the
25 Workforce Race Equality Standard is a shift in those

1 over time. So, clearly, they've only just been
2 published. We would continue to expect those networks
3 to play a full part in not only supporting the analysis
4 and response to that -- those recommendations at
5 an individual organisation level but also be working
6 with management teams in order to determine what the
7 best actions to take and in what order.
8 **Q.** Let me come on to my final --
9 **LADY HALLETT:** I am afraid we are going to have to leave it
10 there, I'm really sorry, Mr Thomas, I know it's tough on
11 all of you who come at the end of the day, but we've got
12 a fair few questions to go through.
13 **PROFESSOR THOMAS:** So be it, my Lady.
14 **LADY HALLETT:** I'm really sorry.
15 Miss Samantha Jones.
16 **Questions from MS JONES**
17 **MS JONES:** Thank you, my Lady.
18 Ms Paget, I ask questions on behalf the Disability
19 Charities Consortium.
20 Now, earlier you were asked questions by Counsel
21 to the Inquiry on the all-Wales thematic review on
22 DNACPR that was undertaken by the mortality review
23 working group. And I would just like to ask you a few
24 more questions about that review if I may.
25 The first question I have is: has that review been

1 published?
2 **A.** I don't know. I asked the same question myself and
3 I didn't have an answer in readiness for my appearance
4 at the Inquiry today, but I will definitely continue to
5 follow it up and I can ensure that that is shared.
6 **Q.** Thank you very much. Secondly then, seeing as we don't
7 have a copy of that review I have a few questions about
8 what it specifically looked at.
9 **A.** Okay.
10 **Q.** Did the thematic review specifically look at whether
11 DNACPRs were used inappropriately during the pandemic
12 for disabled individuals solely as a result of their
13 disability?
14 **A.** I don't think it specifically looked at that but I know
15 that I have seen a conclusion in the nosocomial
16 programme report that said that there had been no
17 evidence of DNACPRs being inappropriately applied. So
18 clearly that's already documented and in the public
19 domain, so that is documented in that report.
20 **Q.** I appreciate you gave evidence earlier about the fact
21 that the thematic review found that conversations had
22 not been documented, conversations with family members,
23 and individuals. But a slightly different point that
24 I would like to ask you about is, did the review look
25 specifically at whether individuals and/or their

1 families were actually consulted about DNACPRs during
2 the pandemic?
3 **A.** So I think it would have been, because it was a review
4 of documentation, so I think it would have reviewed
5 whether or not it was documented that they had been and
6 the quality and legibility of the recording of those
7 conversations. I also know that there was
8 a recommendation that came to say that any
9 correspondence or written communication that they had
10 from patients or families was also to be kept with the
11 DNACPR form as well. So I don't believe that there were
12 conversations with individuals as part of that
13 particular piece of work because it was a review of
14 documentation.
15 **Q.** Do you think it would be a helpful recommendation for
16 a review of DNACPRs and the concerns that were
17 specifically raised, specifically in relation to
18 disabled people, should now be conducted by the Welsh
19 Government?
20 **A.** I don't have a view. I think that we have done a number
21 of reviews of DNACPRs. They have been extensive. That
22 has included HIW, this thematic review and, again, the
23 Nosocomial Transmission Group. I'm not sure what
24 benefit there would be to a further review but clearly
25 if there are concerns that have come through the system

1 to our national lead then clearly they would be quite
2 within their remit to do that for themselves.
3 **MS JONES:** Thank you very much.
4 Thank you, my Lady.
5 **LADY HALLETT:** Thank you, Ms Jones.
6 Miss Gowman.
7 Behind the pillar.
8 **Questions from MS GOWMAN**
9 **MS GOWMAN:** Thank you, my Lady.
10 Mrs Paget, I ask questions on behalf of Covid-19
11 Bereaved Families for Justice Cymru.
12 Photographs were taken in hospitals within Aneurin
13 Bevan University Health Board. Some of those
14 photographs included photographs of patients being
15 treated, and body bags. Were those photographs taken
16 with patient consent or the consent of their family
17 members? If not, should those photographs have been
18 taken and published online without such permission?
19 **A.** So, one of the conditions on any agreement for the
20 taking of photographs was that consent was to be
21 obtained from the patient, from members of staff or
22 family members. If a patient was ventilated and then
23 recovered then the consent was to be retaken when the
24 patient was well enough to do so.
25 So an absolute requirement was that consent was to

1 be sought and documented.
2 **MS GOWMAN:** My Lady, may I ask a follow-up questions in
3 respect of the process by which consent was obtained
4 from severely unwell patients, patient dignity, and the
5 impact on the bereaved?
6 **LADY HALLETT:** I think we have probably got enough, I am
7 afraid. I take the point, Ms Gowman.
8 **MS GOWMAN:** I will move on.
9 **LADY HALLETT:** I know -- I've heard a lot of about this, as
10 you can imagine, directly from the Welsh bereaved.
11 **MS GOWMAN:** Thank you, my Lady.
12 **LADY HALLETT:** And I will hear more from them.
13 **MS GOWMAN:** Yes.
14 On that basis, Mrs Paget, I will move on to
15 discuss the national nosocomial Covid-19 end of
16 programme learning report which was finalised in
17 August 2024. Now, those I represent are highly critical
18 of what they consider to be the superficial nature of
19 the learning points in the final report with some
20 significant issues they say being underplayed or omitted
21 and I'd like to touch on the process by which the report
22 was compiled and some of the deficiencies that they have
23 identified.
24 Firstly, what steps have you taken to satisfy
25 yourself that all nosocomial deaths in Wales have in

1 fact been recorded as patient safety incidents?
2 **A.** So, as part of this programme, as you will know, there
3 were changes made and focus given to the making -- to
4 ensuring that all nosocomial transmissions or
5 healthcare-acquired infections in hospital were reported
6 through a national reporting system. So that's been
7 consistently applied across NHS Wales.
8 **Q.** And are you satisfied that it has been consistently
9 applied and that all nosocomial deaths have been
10 recorded in the way that you suggest?
11 **A.** I have to rely that the system has done what it's been
12 asked to do. I understand over 18,000 cases have been
13 reviewed as part of this process, which is a substantial
14 number. I have to rely that the process of having
15 a clear specification and a clear process and
16 a consistent process across NHS Wales has meant that we
17 have captured all cases.
18 **Q.** But presumably this was a relatively new process. Are
19 there no checks and balances or audits that can be
20 carried out to verify that they've all been recorded?
21 **A.** So I think that I would probably need to go away and
22 check myself with those who might have been closer to
23 the audit than I would have been and it would probably
24 be wrong of me to speculate, but I know that in
25 organisations whenever there was an outbreak or whenever

1 anybody was deemed to have got Covid-19 whilst in
2 hospital, there was a really clear criteria about making
3 sure that we were clear had that been community acquired
4 or hospital acquired, and that was consistently applied,
5 to the best of my knowledge, throughout the pandemic.
6 **Q.** Moving on then in terms of a particular deficiency that
7 the group has identified. Do you accept that the report
8 doesn't fully address cluster outbreaks that occurred in
9 Wales?
10 **A.** So, I -- the report, as I've read it, clearly it's not
11 a Welsh Government report, it was done by the NHS, but
12 I have, clearly, read it. Does it make specific
13 references to clusters? But I do know that they clearly
14 would have been investigated through the normal incident
15 management team that investigated every outbreak. And
16 that was based on my -- obviously my experience of
17 working in Aneurin Bevan.
18 **Q.** But the report itself doesn't identify underlying causes
19 for outbreaks, doesn't identify, for example, the
20 effectiveness and implementation of IPC guidance and any
21 contributory factors in that regard toward outbreaks,
22 does it?
23 **A.** So it doesn't make any recommendations around broader
24 clusters, but clearly the recommendations around
25 infection prevention and control, PPE, the state of the

1 NHS estate and all those things would be factors in any
2 cluster outbreaks as well as individual cases.
3 **Q.** But without looking specifically at the detail and root
4 causes of clusters, do you agree that the learning
5 points in the report are somewhat limited?
6 **A.** I think that the reviewers would have determined that
7 the lessons learnt from clusters and investigations of
8 outbreaks at ward or departmental level or hospital
9 level are already captured and with Public Health -- and
10 with Public Health Wales.
11 **Q.** And can I ask, Mrs Paget, is this report intended to be
12 a key part of NHS and Wales' learning on nosocomial
13 infection?
14 **A.** It absolutely is. It's not the only thing, of course,
15 but it is a really important piece of work. And as
16 I said earlier in response to a question from Mr Mills,
17 we will be ensuring that there is follow-up within the
18 NHS Executive on this report and that we get, in Welsh
19 Government, a quarterly update on the progress against
20 the areas identified for action.
21 **Q.** And my final question.
22 Given that it is to play a role in NHS in Wales'
23 learning, in light of the deficiency that
24 I've highlighted, do you think there's any merit in
25 further exploration of what contributed to nosocomial

1 infection in Wales?
2 **A.** So, I think -- so, my view would be it is recorded and
3 documented. What we will need to ensure is as this
4 piece of work now moves forward that there are the
5 opportunity for Public Health Wales to continue
6 contributing learning as they've got it recorded in
7 terms of that. But just to say that's been there for
8 a little while now, it's not a new thing, so
9 Public Health Wales will have, and NHS organisations
10 will have a lot of information around the issues that
11 contributed to outbreaks. And clearly, as part of
12 infection prevention and control policies and practices,
13 those things will have already influenced what is
14 happening.
15 **MS GOWMAN:** Thank you, Mrs Paget, no further questions.
16 Thank you, my Lady.
17 **LADY HALLETT:** Thank you, Ms Gowman, very grateful.
18 Thank you very much for your help, Mrs Paget.
19 We've now completed the questions for you and we don't
20 have to do what we asked Dr Goodall to do. We have
21 completed you today.
22 **THE WITNESS:** Thank you, my Lady.
23 **LADY HALLETT:** 10 o'clock tomorrow.
24 **(The witness withdrew)**
25 **(4.11 pm)**

1 **(The hearing adjourned until 10.00 am**
2 **on Thursday, 14 November 2024)**
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