Tuesday, 20 May 2025

(10.00 am)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Please could the witness be sworn.

MR DAN YORK-SMITH (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Good morning. Please could you give your full name to the Inquiry.

A. Yes, Daniel Byron York-Smith.

Q. Thank you. Mr York-Smith, you have provided the corporate witness statement on behalf of His Majesty's Treasury. It's dated 7 April 2025. Can we turn to internal page 55, please, where we see your signature and statement of truth.

And can I ask you, in respect of this corporate statement, can I ask you to confirm, are the contents of the statement true to the best of your knowledge and belief?

A. Yes.

Q. Now, it's clear that a huge amount of work has gone into the corporate statement, and perhaps if we start with identifying you and your role. It's right, isn't it, that you are director general for tax and welfare at His Majesty's Treasury?

A. Yes.

Q. And at the time of the pandemic and these events, you were director of strategy planning and the budget group at His Majesty's -- well, Her Majesty's Treasury at that time; is that right?

A. Yes, that's correct.

Q. Before, then, we get into the detail of the department, can you just give us some idea as to how long you've worked within the Treasury, please?

A. Yes. So I've been in the Treasury for just over 20 years in a variety of roles. I spent a brief time out of the Treasury on secondment to the Prime Minister's Office.

Q. Thank you. Now, it's right, isn't it, that in addition to a large volume of material that sits alongside this statement, there are also a number of appendices that help to clarify what was happening and the Treasury's role and involvement?

A. Yes.

Q. But beyond this, we have also received the relevant statement from the Chancellor dealing with his decision making, relative to some of the matters that I'm going to be asking you about today.

A. Yes.

Q. And I think, as a civil servant, you're particularly anxious that I clarify the remit of your assistance

today, and that you weren't the decision maker?

A. Yes, that's right.

Q. Thank you.

Can we, then, please, just capture the position of the Treasury because I'm going to be asking you some questions to see if you can assist today a little more in respect of the Statutory Sick Pay system, the England-only Test and Trace Support Payments, decisions on funding for the expansion of testing, inequalities and then some recommendations.

But if we, perhaps, identify the decision makers in the Treasury, please. If we please move to your paragraph 8, at page 3 please, of the statement.

Again, I'm not going to spend time on this, her Ladyship is well aware of the structures, having heard evidence.

It's right, isn't it, that the Chancellor and the Chief Secretary to the Treasury are responsible for public expenditure?

A. Yes.

Q. And that the Treasury officials assist in decision making by advising ministers?

A. Yes, that's correct.

Q. Thank you. And I think you detailed at paragraph 10, the role of the Treasury is to set budgets, apply

spending controls, and influence strategic decisions. And I think when we come on to the testing, it's right, isn't it, that the Treasury in a later period did then exert some control on spending relating to testing?

A. Yes, that's right.

Q. Thank you. But having said that, I think it's right to acknowledge the huge volume of funding that was provided to support the testing.

A. **(Witness nodded)**

Q. You deal with it within this statement more broadly, but it's right, isn't it, that the total budget for the 2020-2021 period for testing provided was 22 billion?

A. Yes, that's right. It increased at various points. The final budget was 22 billion.

Q. Thank you. And that's just for the 2020-2021 --

A. Yes.

Q. -- I'm not going to get into further details.

So when we look at the detail around the isolation aspect that we're going to look at, I think the wider context as to funds attributed to the Test, Trace and Isolate system need to be understood. Thank you.

Now, can we also confirm together that in the context of Test and Trace in England, financial support for those self-isolating in the form of Statutory Sick Pay is a reserved matter in Great Britain.

Perhaps if we just look at your paragraph [11] -- thank you. Because it's right, though, isn't it, in respect of health that is a devolved matter, and policies around testing, tracing and isolating in the event of an infectious disease are dealt with by the devolved administrations.

A. That is correct. I would say, also, that with respect to the reserved policy on Statutory Sick Pay, the Northern Ireland Executive have generally tended to follow the approach of Great Britain, so although the Treasury didn't make policy, it was likely that that policy would be adopted in Northern Ireland too.

Q. Thank you. I don't think we'll need to get into the detail of this with you, but I think it may be relevant to some of the evidence we hear later. It's right, isn't it, because health is devolved, where the Treasury increased the spending allocation for health, essentially there's a Barnett consequential, there's a process it goes through to essentially give the equivalent extra allocation to the devolved nations to reflect the uplift in spending that's been allocated to health?

A. That is correct. I understand that this has been covered in previous modules to the Inquiry, but there was a kind of wider approach to how to give the devolved

government certainty about the amount that they would receive, given the fact that the increase in resources allocated to Test and Trace was -- and indeed the wider health system -- was evolving very quickly.

Q. Thank you. Can we then, please, deal with some details relating to the Statutory Sick Pay, and that can be taken off the screen. Thank you.

It's right, is it, that as a general position, Statutory Sick Pay pre-March 2020 was paid for by employers from the fourth day of illness with no entitlement to workers for the first three days?

A. That's correct.

Q. It was paid at that time at a rate of £94.25 for 28 days.

A. Correct, yes.

Q. And also employees were only entitled to that payment if they earned over £118 per week?

A. I believe it was 120 was the lower earnings limit, yes.

Q. Thank you. And it obviously follows that Statutory Sick Pay does not cover those who are self-employed.

A. Yes.

Q. And perhaps can we just look, for the first portion of my questions on Statutory Sick Pay, at the changes, but also the process that led to those changes, please.

Could we look together, please, at paragraph 116

which is on page 31. And I think it's right that the change that happened in respect of Statutory Sick Pay, on 11 March, the Chancellor announced that Statutory Sick Pay would be available from day 1 and was extended to those who were self-isolating and to carers for individuals who were self-isolating because of Covid-19?

A. Yes.

Q. Thank you. Can we next then move, please, to a document, just to look at the progression relating to Statutory Sick Pay, please, and its adequacy.

Please, could we display INQ000585998. Thank you. And can we move into page 3 of this document.

Now, Mr York-Smith, on 19 March, the officials prepared a paper including a number of options including increasing the rate of Statutory Sick Pay and removing the lower earning limit to Statutory Sick Pay, and the increase to the Statutory Sick Pay was not included in the package of welfare measures that were then announced the following day on 20 March, but we can see that there's consideration in respect of that within this document. But can I ask you, why, then, was the increase to the Statutory Sick Pay not included then in the measures that had been announced on 20 March?

Are you able to give any clarity around that, please?

A. So that was a decision for the Chancellor on the basis of this advice. I could offer a bit of context to the wider package of announcements that were made on 20 March, where the Chancellor announced a number of measures which were intended to address the economic consequences of the restrictions that were being put on businesses and individuals, some of those yet to be fully announced and were announced the following week, and so the Chancellor had asked for advice on the furlough scheme, what became the furlough scheme, support for the self-employed, but also recognised that one of the economic consequences might be an increase in unemployment and therefore wanted measures in the welfare system to address that, so this was primarily targeted on the economic shock as opposed to isolation.

What he -- what his office said in one of the other documents relating to this table was that his priorities were simplicity, operational delivery, and things which are clearly for the current situation rather than the longer term. So that was what I can say about what his office said about his decision making, but it was in the context of a package aimed at -- particularly reflecting on the fact that there might be an increase in unemployment as a result of some of the restrictions.

Q. Thank you. Can I ask you just slightly to slow down

when you're giving your answers --
A. Sorry.
Q. -- just to help the stenographer, thank you.
That can be removed from the screen.
And perhaps if I give a context to the questions I'm asking about the Statutory Sick Pay and when we move on to the support to isolation payment, it's because the Inquiry is seeking to explore what financial provisions there were to assist those to isolate and then what impact that had may have had on those decisions around isolation, so that's why we're looking at the context.
Can I then ask just some additional questions, please, on the Statutory Sick Pay: are you able to assist, what was the Treasury's role in decision making regarding the adequacy of Statutory Sick Pay for those required to self-isolate during the pandemic, just to give a broader context, please, to that, appreciating that -- the "shock" answer you just gave and the impact it could have on restrictions.
A. So Statutory Sick Pay policy is the responsibility of the Department for Work and Pensions, but because of the costs to businesses, because Statutory Sick Pay is paid by businesses, the Chancellor and the Treasury have an interest, and so it has been the case that Statutory Sick Pay has generally been made in -- changes to it

have been made in budgets. Not necessarily, there has been a recent change to Statutory Sick Pay which was announced by the Department for Work and Pensions which has made some changes to the policy, which we might come on to later.
Obviously the changes to eligibility, the waiting days, the requirement for a fit note and so on, and it being made available for self-isolators, was made in the budget in 2020. So we have an interest in terms of also the trade-offs between the cost to employers and the impact, the potential impact on employment, increasing the cost to employers of employment-related rights like Statutory Sick Pay.
Q. Thank you. And thank you for giving the broader context. Can I then ask, was any assessment made by the Treasury of whether Statutory Sick Pay eligibility criteria, such as the minimum earnings threshold, excluded vulnerable workers, and if so, how this is to be addressed?
A. So in the table that you previously showed it was noted that removing the lower earnings limit would increase the number of people eligible for Statutory Sick Pay by 2 million people. But the other consideration in the advice for the Chancellor was about the fact that a number of people's earnings -- if their earnings were

lower than the amount of Statutory Sick Pay, you might create a perverse incentive for people to be sick rather than working. So we sought to contextualise the wider system, and indeed the rates of welfare through the Universal Credit and so on.
Q. Thank you.
Now, appreciating that there's a portion of your statement already that deals with questions and issues of inequalities, but particularly around Statutory Sick Pay, are you able to assist any further with the extent to which Treasury decision making on Statutory Sick Pay took into account the disproportionate financial hardship regarding self-isolation to minority ethnic communities?
A. So I'm not able to add to what is in my statement on this. I guess I would say my recollection at the time is that the question of self-isolation was not a question which was being raised with the Treasury by the Department for Health and Social Care, who are responsible for self-isolation policy as it is a health policy, because at that point testing was primarily in hospital settings. There wasn't community testing.
We had, on 20 March, not actually required people to stay at home, so I think it was a feature of our advice later in the pandemic, particularly on thinking about

restrictions, and I'm sure we'll come to it in some of the later documents, but at that point this was through the lens of the economic shock rather than thorough self-isolation.
Q. Thank you. Can we then, please, display your paragraph 118 at page 31, please.
Now, on 8 April 2020, officials sent advice to the Chancellor regarding an extension of the Statutory Sick Pay to those shielding and told to stay at home for 12 weeks, with an estimated 900,000 extremely vulnerable people having received a shield letter.
And, obviously, you detail within this paragraph here, refer to the department of work and pension estimate that 200,000 of those 400,000 sent letters were employed in anecdotal evidence, through MP's correspondence, suggested there were cases where employers were refusing to furlough someone being shielded or to pay them for that period, and the advice of the Chancellor recommended an extension to cover this cohort which was agreed by the Chancellor.
If we then go to paragraph 119, please, over the page, you've also detailed that further advice was provided to the Chancellor noting growing pressure to consider further support to those clinically extremely vulnerable who had been asked to shield.

Can we look, please, at the email that went alongside this time of 22 May, please.

It's INQ000585929. Thank you.

If you want to orientate yourself, it's one of the documents provided to you. Thank you.

Can we move then within the email to page 2 please. Thank you. Essentially -- sorry, we can go back a page. Thank you.

Essentially it references that there's a lot of Whitehall pressure to announce something "next week on this".

Are you able to assist us as to what the pressure exactly was around the advice from officials on 22 May 2020 in the context of Statutory Sick Pay and support for isolation?

A. My understanding, my recollection, is -- and from the other documents -- that this was less specifically about the Statutory Sick Pay. This was about the financial support for those people who were shielding, and the advice itself notes that that's in the context of a potential change to the shielding programme but also to the Coronavirus Job Retention Scheme where it was intended that there would be employer contributions from later in the year and therefore the willingness of employers to provide support to furlough people who were

Q. Thank you -- "and the shielding programme, officials provided advice to the Chancellor. The advice noted there was growing pressure to consider options for further support and sought initial policy steers regarding future financial support to the 'clinically extremely vulnerable' people."

I think I've already asked you about the pressure, it's no different there to what we see in the email.

A. Yeah.

Q. Thank you.

You tell us:

"The advice noted that upcoming changes in employer contributions to [furlough] and a pending review of the shielding programme would increase pressure to clarify the financial support available to the clinically extremely vulnerable."

So this is now a second reference to increasing the pressure. And can you just give us some context as to who was providing the pressure that you're referencing there?

A. I -- I probably have to assume that it was people affected by the change -- by the increase in the -- by the fact that, as the witness statement says and in the submission which we disclosed, that the changes might mean some people who were able to be furloughed, their

shielding might be reduced.

So I think it was in that wider context rather than specifically being about Statutory Sick Pay.

There was a question about whether to extend the rebate that had been introduced for small businesses to help them meet the cost of Statutory Sick Pay, but this advice was more about financial support for the clinically extremely vulnerable, given the changes to the shielding programme and to the furlough scheme.

Q. And, again, with the reference to "pressure", are you able to help us with what the pressure that's being referenced there was?

A. I don't know -- I'm not able to add to that. I don't recall exactly what was being asked for.

Q. Okay, thank you. Can we then take that down and use your witness statement again at paragraph 119 to help us navigate the rest of my questions on Statutory Sick Pay, please.

You tell us that:

"On 22 May, ahead of planned announcements on the future of CJRS ..."

Can we just confirm what CJRS is.

A. That's the Coronavirus Job Retention Scheme --

Q. Thank you -- furlough?

A. Furlough, yes.

employer might no longer furlough them because the employer had to provide a contribution, whereas in the early part of the scheme they didn't, and the fact that a larger number of people potentially would be asked to shield, so the review, one potential outcome of the review was to increase from 2.2 million of the population advised to shield to as many as 16 million, and therefore there might be additional people who were being advised to shield and would request financial support.

Q. Thank you.

Just continue with this paragraph, you tell us that:

"The advice recommended that the Chancellor hold off making decisions on further support for shielders until more clarity was provided by the [Department of Work and Pensions], the MHCLG and [the Department of Health and Social Care] on the characteristics of the shielding cohort ..."

Then it goes on:

"The advice also asked for a steer to work up further income support options for the shielded group. Ultimately, the [Chancellor] decided that [Statutory Sick Pay] was sufficient at the time but indicated he was content to consider this again once further clarity and evidence on the shielding programme was available."

So can I ask you, are you then able to help us on what was being done more broadly to give the evidence to the Chancellor to inform what was needed for other financial support schemes, please?

A. So that advice covered a range of things, and particularly I think the uncertainty was about the size of the shielding programme. So 2.2 million, the 2.2 million people we understood more about the characteristics of. The 16 million, if it were to be expanded that far, we didn't have the same information on the characteristics of. I think the advice notes that on average, someone who was furloughed was receiving £253 per week, and that compared to £95.85 of Statutory Sick Pay, £94.59 for Universal Credit, £74.35 for the Employment Support Allowance. So some of it was about the context of what support was available for those people now versus the support that might be available if the programme was expanded.

It recommended looking at particularly the economically active group within that. Not everyone who might be asked to shield or was shielding was in work. And the advice was to focus on that.

Q. Thank you.

Can we then, please, look at INQ000585068, please, which is the submission from the Treasury which was

titled "Financial support for the shielded", dated 22 May. And then perhaps if we can move within that document to paragraph 7, please, where some analysis is provided as to the Department of Health and Social Care suggesting that of the 2.2 million asked to shield, 29% normally work. Of this group, 38% are working from home, 43% (sic) say they cannot work from home, and 13% say they can work from home but have stopped or are furloughed. And I think the latter two groups are considered to be the most exposed to income shocks as they're unable to work unlike pensioners or long-term sick supported.

And we can see it says:

"As a maximum, we recommend targeting any further support at the economically active group."

Now, again, in the context of the questions I've asked you about pressures, as well, are you able to help as to whether you, the Treasury, or the adviser to the Chancellor, undertook any analysis of the number of people who were clinically vulnerable and shielding or who would be required to stay at home due to having Covid-19 symptoms, and whether that may impact on them not following the guidance to isolate?

A. So I think, because the isolation policy was generally -- was a health policy, it was the Department

of Health and Social Care who were the most able to do that analysis, and that is what this excerpt that you've highlighted is intended to do, is to -- of the 2.2 million, who are the people who can't work from home or have stopped working or are furloughed, and that was why the advice was that those were the people that the Chancellor should focus any further -- any financial support on.

Q. Thank you.

Now, the last questions on Statutory Sick Pay before we move to the test, trace and support payments, could I ask, please, for the display -- INQ000585069. Which is an email of 29 May 2020. Thank you.

LADY HALLETT: Sorry, just before you go on, you say, Mr York-Smith, that the isolation policy is health policy.

A. Yes.

LADY HALLETT: I understand that. Do you remember the DHSC presenting the Treasury with any papers to argue that it was important to ensure that people would isolate by being properly supported financially?

A. So I think when we come on to the Test and Trace Support Payments, that was where I recall that ... partly, I think, it reflected the changing nature of the restrictions and, at a point where many settings were

closed, it wasn't something that there were lots and lots of discussions about. As we opened settings and moved -- began to develop a test and trace system where people could know whether they tested positive and isolate, it became a thing which was discussed and I think particularly with respect to the Test and Trace Support Payments.

LADY HALLETT: Thank you. Sorry, I went too early.

MS CARTWRIGHT: Not at all. Thank you.

So we're back with the email of 29 May, please, and we can see it was reported that:

"[The Chancellor's] view is that there was no rush to work up a 'new' solution, his starting point is that there should be no income replacement stream, that [Statutory Sick Pay] is adequate."

And there's reference again to:

"... a bit of pressure from some quarters ... to come up with a more generous answer on this [question] of financial support for shielders (and isolators). The clear steer from [the Chancellor] is that he's happy for you to work up targeted income support options for shielders, when there's further clarity on the shielding programme, and on the basis of evidence etc in the usual way."

Are you able to help us with any clarity as to why

it was felt there was no rush at this stage, bearing in mind we are now 29 May, and obviously the strategy in respect of test, trace and isolate was issued in May?

A. So I can't elaborate on the decision making, and particularly the way it's expressed, other than it was a response to that -- the advice which recommended that we do work up an income. I think the previous document we looked at recommended that we work up an income support scheme.

Q. Thank you. In respect of that income support scheme, was there any thought as to what that was going to look like and who was tasked with creating that income support?

A. As it was, the Chancellor said that he -- that there was no rush, and therefore we should -- and that it was adequate. I think -- well, we'll come on to it with the Test and Trace Support Payment that, a lot of this, the Treasury's role was about scrutinising the proposals to spend taxpayers' money and providing that sort of scrutiny rather than necessarily developing the support scheme which was within the context of a programme for the shielders, clinically extremely vulnerable, which was a combination of the Department for -- the Ministry, rather, for Housing, Communities and Local Government and the Department of Health and Social Care.

Q. Thank you.

So let's move on now to any further assistance you can provide beyond that in the statement around decisions on the Test and Trace Support Payment Scheme. And perhaps just to help us all, and just to remind us all, can we display a helpful table within that expert report that the Inquiry's received from Professor Machin.

It's INQ000575999. Thank you.

And the Inquiry's already heard some evidence that the schemes as they operated across the four nations differed, but we can see there England's Test and Trace Support Payment that came in in the October of 2020.

Perhaps if we just go over the page, so we've also captured Northern Ireland's discretionary scheme that was introduced in the March of 2020, thank you.

And then, just whilst we're in the report of Professor Machin, just to identify the principle I've already indicated why I'm asking you these questions, can we look, please, within the report -- if we could move forward to page 8. Thank you. And just paragraph 4.

The reason why I'm asking in particular about this next scheme is Professor Machin has identified:

"This report finds that there is clear evidence that

the ability and willingness to self-isolate is linked to financial status. The [United Kingdom] Government acknowledged the risk that people would not self-isolate because of their financial circumstances."

And then obviously he goes on to make some recommendations.

So if we can take that from the screen, please.

Seen with some of the emails we've already looked at, was it understood within the Treasury that if there wasn't adequate financial support that people wouldn't isolate, and that had an ability to undermine the whole system of test, trace and isolate?

A. I think, if I could put it in some wider context, there were a number of -- a very large number of schemes introduced through the early part of 2020, which intended to support people with the -- particularly the economic impacts of the pandemic, through the furlough scheme and the self-employed support scheme.

Those provided significant support for many people, including support if you were isolating, but as I know the Inquiry will consider in a later module, there were people who were not eligible for those schemes by reasons of design and delivery and the trade-off between that and the potential for fraud and perverse incentives.

The Treasury was very supportive of a functioning test and trace system, and spent a lot of time producing analysis of the potential economic benefits of a functioning test and trace system. So we definitely recognised that it was very important to -- very important to have a functioning test and trace system.

As I expect we'll come on to with the documents, the Chancellor was particularly concerned about the perverse incentives that might be created and the ability to target those people who weren't being supported by the other schemes. So he definitely recognised the importance of the system working. Some -- as always, because this was spending taxpayers' money, wanting to scrutinise what the evidence was, and also to target those people who needed the support, and avoid issues like giving money to people who had no loss of income, controlling for fraud, and the delivery of the schemes, which was particularly difficult.

Q. Thank you.

Now, can we -- I'm going to look at the SAGE advice of May and then I'm not going to able to look at the various correspondence, advice, that look at the evolution of the thought process around the need for there to be adequate financial support to isolate, but if I can use the SAGE advice as -- of 1 May, please.

Can we display, please, INQ00061540. Thank you. And if we could move within that document to page 3.

It's just paragraph 20 I want to ask you about please. So this is SAGE identifying:

"A high level of adherence to requests to isolate is requiring for the system to be effective."

And the following paragraph:

"Risks include individuals becoming less willing to comply if they are repeatedly asked to isolate and if they are impacted financially from being asked to isolate."

And was it well known and this advice of SAGE understood in the department in May of 2020?

A. I can't -- I'm afraid I don't recall whether this particular SAGE readout was widely known about in the Treasury.

Q. Thank you.

LADY HALLETT: But the principle?

A. The principle, yes.

MS CARTWRIGHT: Thank you.

And I know, as part of the documents you've provided, and the submissions, the documents for the preparation today, there's then a train of advice, documents, emails, that again flag time and time again -- would you agree? -- this principle.

So what I want to ask you about is that, bearing in mind it was many months before that isolation support scheme came in, can you help us to understand the tensions, what was happening, was it being ignored? What was the reason for the delay in introducing an isolation support package, please?

A. So I suppose I should go back to, the isolation support scheme was part of a test and trace system, and therefore it was the responsibility of the Department of Health and Social Care, and when the Prime Minister requested options for this, they were requested from the Department of Health and Social Care, the Treasury, and the Ministry for Housing, Communities and Local Government, reflecting the fact that DHSC were the lead department for this.

The potential delivery mechanism involved local authorities, and so it was for MHCLG, and then the Treasury's role was, as is the case on this whole programme, to scrutinise the costs, the evidence and provide advice to the Chancellor and then for the Chancellor to decide.

So, as to the time taken for something to be announced, there were a number of factors that we had to reflect in our advice, and then there was a difference of view between ministers and there was a discussion

between ministers about what the policy should be, reflecting the fact that the Department of Health and Social Care would be the department responsible but the Chancellor had to authorise the expenditure.

Q. Thank you. And just on that point can I ask you, because part of the documents that have been provided to you is the email of 19 June of 2020 that stated that the Prime Minister himself had raised concerns about the possibility that people might feel compelled to not comply with guidance to isolate due to financial pressures.

So factoring in the Minister's views, and in particular this is the Prime Minister himself on 19 June, can you assist why it was not done sooner when the Prime Minister himself and, I think also in the correspondence, Dido Harding was raising the need for there to be this isolation support?

A. So that, if I could put in context some of the rest of that commission, it also said that the Prime Minister shared the Chancellor's position that everything else equal, we would not want to act where there's a risk of setting a precedent and creating liabilities for longer-term increases to welfare support, and that commission itself went to the Department of Health and Social Care, the Treasury, and MHCLG, so the role for

designing the scheme was for the Department of Health and Social Care, obviously with Treasury input as regards our responsibility to scrutinise the cost and other features of the design, in order to advise the Chancellor.

So that was the beginning of a process which involved discussion between three departments which led to the announcement, in late August, of the regional pilots of what became the Test and Trace Support Payment.

Q. Thank you. Now, I know you've had provided to you in the pack, as well, submission from the Treasury from August 2020 where it was suggesting an option of £330 based on the -- sorry, perhaps we just display that so I can contextualise the question, please.

INQ00585074, please, and it's internal page 5.

And, essentially, it was a document itself that was identifying the need for the National Living Wage. Thank you. So page 5, paragraph 16, and if we keep moving through the document, please. Thank you. If we move along I think there may be -- move along again, please. Thank you.

And so are you able to assist at all in the thought processes why, when there was the figure -- the option of 330 being identified, why that didn't feature sooner?

A. Sorry, it's displaying a different page so I'm --
Q. Can we go back, please, to paragraph 16, thank you.
A. So I think this illustrates the point that I made about the Chancellor's view that he was concerned about the -- how this payment would fit in with the wider system of support, and particularly worried about perverse incentives where you might be paid more to isolate than you were paid in work, where there was something, at the time there was something like 6.5 million people who earned less than 35 hours at the National Living Wage. And so -- and that, you know, the rates of Universal Credit and so on. So it was really in that context.

I think this is pointing to a debate that was had at the time about whether this was income replacement or whether it was an incentive. So was it compensation or an incentive that we want to provide, where compensation would be much more complicated to deliver because you would need to understand what people's incomes were, and an incentive would be more straightforward, administratively.

Q. Thank you. Can we then please display your paragraph 148, please, on page 38, which is now when we get to the 500 figure, which was the figure introduced under the TTSP, thank you. So paragraph 148:

"As the requirement on self-isolation changed to

require individuals to isolate for a shorter period of time, the flat rate £500 TTSP payment became more generous in relative terms ..."

I think it's the position you just set out, and I think you've done your analysis depending on what the isolation periods were, whether they were the 14 or reduced to the seven, what that meant for a daily figure.

And could I ask you, looking at those figures and appreciating it depended on what the isolation requirement was, do you agree that for many workers receiving £35 or £50 a day would represent a significant reduction in their earnings during the period of self-isolation and is well below minimum wage if someone is working full time?

A. So that is factually true. I guess, to the point that I made earlier, there were 6.5 million workers at the point that we're talking about, who earned less than 35 hours at the national living wage, so the scheme needs to account for working patterns and income levels and as I say, by moving to a flat rate payment it was very much more an incentive payment than it was earnings replacement.

It was also designed only to be for those who had lost income as a result of self-isolation. 68% of

employees received more than Statutory Sick Pay as part of their employer's sick pay offer. So the setting of the payment was a question about trading off the incentive effect, the deadweight cost of people receiving more than they would receive otherwise, the incentive cost, and the higher the payment, the greater the risk of fraud. And there was some evidence that there were fraudulent claims of the payment.

Q. Thank you.
A. Sorry.
Q. Can I ask you, when Wales increased their isolation payment in August of 2021 to £750, and obviously that uplift was in place until the January of 2022, can you assist as to what thought was given internally within the Treasury that a similar uplift should then, as a matter of equity or fairness, equally apply to the scheme operating in England?
A. I am afraid I can't -- I'm not -- I don't recall seeing any consideration about that, but by that point, it was, because of the restrictions and the testing and tracing regime and vaccination and so on, it was a much smaller part of the overall picture of Test, Trace and Isolate.
Q. Thank you. I'm going to move then, briefly, on to the topic around testing, please, and funding for testing.

Can I ask, how did the Treasury decisions on the

scale and scope of funding for community testing initiatives ensure that high-risk groups including ethnic minority communities were prioritised?
A. Generally, on funding for testing, the Treasury took a very, very flexible approach. And I know that some of this has been covered in previous modules on vaccines, so I won't do this at length. But the Treasury approved almost all of the -- very quickly, the requests from the Department of Health and Social Care for the resources they required for testing, and that saw a very quick ramp-up in the expenditure on testing from sort of tens of millions in March 2020 to 10 billion by June 2020.

And that, that envelope was then for the Department of Health and Social Care to allocate. So the Treasury would not have taken a view on the allocation of the testing other than continuing to challenge the Department of Health and Social Care about having a strategy for using the testing, and to ensure that there wasn't unused capacity, and so I think the question of how to use the testing capacity and its impact on equalities would be a question for the Department of Health and Social Care.

Q. Thank you.

Can you then help us, please, with what you tell us in paragraph 51 of the statement, please. It's page 15.

INQ000587305, please. And really, it's the view that the Treasury was expressing as to the effectiveness or efficiency of testing in the context of the substantial funding. You say this at paragraph 51:

"As England continued to reopen over the summer, there were some concerns around the effectiveness of the [test and trace] system. [The Department of Health and Social Care] advocated for an expansion of the [test and trace] system, however Her Majesty's Treasury officials wanted to first forecast on addressing the performance issues within the programme and improving cross-Whitehall governance to ensure that the strategy was deliverable, better targeted/prioritised on the basis of evidence, and more fully utilising testing capacity that had already been procured."

Then we can see on the next paragraph you provide some further details on the SAGE advice about the needing to identify 80% of contacts.

And then are you able to help us at all as to the concerns, how the concerns were crystallising in the Treasury but also what lay behind the poor performance, resourcing or operational issues, from the Treasury's perspective, please.

A. First, I should recognise that the test and trace -- the NHS Test and Trace was a very new organisation, Dido

Harding been appointed in early May. It had launched in late May. And it was -- the Treasury's objective here was to try and get the balance right between being supportive and challenging and recognising the enormous endeavour of going from very limited testing to a very widespread testing.

That said, we recognised the economic case for funding testing, and driven by the SAGE advice about the potential impact on transmission of the virus if you had an effective test and trace system, but we had concerns about how deliverable it was, so whether there was sufficient capacity to do the tests, so whether we had unutilised lab capacity, whether the testing was being targeted at the highest risk settings, the highest risk groups, to your earlier question about equalities impacts, but also to the highest risk areas of the country and that we didn't have capacity that was going unutilised and there was evidence that utilisation was low in some areas.

There was also, I think, because the expansion was extremely quick, there wasn't necessarily a strategy for how best to use the testing, and there wasn't sufficient financial control, so as evidenced later in the year, we approved the budget of 22 billion but in the end, towards the very end of the financial year, 2021, the

underspends grew from, sort of, 300 million to 5 billion, 7 billion, and in the end, it underspent by 9.5 billion and there are obviously opportunity costs to that in terms of the ability to raise the finance, and whether that money could have been used elsewhere.

So we wanted to support, but equally we wanted to challenge to make sure this very significant investment of public money was delivering all of the objectives that it could, both economically and for the health outcomes.

Q. Thank you. And I think that answer may have pre-empted this question, but perhaps if there's anything else you want to say. Obviously, we know that it was the Department of Health and Social Care's responsibility for the Test and Trace System, and really, so why was the Treasury challenging the Department of Health and Social Care's proposal to expand Test and Trace?

A. I think, yeah, there's not much I can add to what I said, which is before expanding, we wanted to see that it was delivering its objectives, and as it was, we did agree to expand, and I think it was not until October where we recommended that there might be a pause.

The other point I would add, is that the technology for testing was changing. Whether the tests were effective was a question that was asked at the beginning

of the pandemic, through the pandemic different testing technologies became available, and the Treasury was very permissive and flexible in the way it approved spending, recognising this very rapid development but like I say, we wanted also to challenge to make sure it was being used effectively.

Q. Thank you. Can we then take that down and move to paragraph 61, please, of the statement at page 18.

Now, we can see that you've identified in a meeting of 12 August 2020 to discuss population-wide testing, the Prime Minister emphasised that obstacles raised by Baroness Harding involving the Cabinet Office and the Treasury approvals should be removed.

The Inquiry has already heard in module 5 Lord Agnew speaking about spending approval and testing, and short timeframes for approval.

Can we just look at a relevant email, please, which is INQ000471020, which is an email exchange before this meeting, of 23 July. Thank you. And if we move to page 3, please. Thank you.

We can see, essentially, Lord Agnew was concerned about the position, essentially, of being asked to approve one and a quarter billion programme in one day, and obviously we can see Gareth Rhys Williams commenting that:

"Whilst I get the political imperative is to set this up and fast, there are aspects I'm really not happy about."

Can I ask, is this is an example of a barrier related to Cabinet Office commercial controls that you were referencing in the paragraph 61 that we looked at together, or is that a different issue that's being raised in this email?

A. I think the Lord Agnew comment is particularly about the size of the approval and the amount of time given to consider it. The Cabinet Office commercial controls were -- are more about the approval of individual contracts. I think this is an example of the spending approval process and whether sufficient information and time has been given. Generally through the pandemic, the Treasury was extremely flexible and extremely quick to approve, but there is a balance that needs to be struck.

Q. Thank you. Can we then, just to complete this portion of questioning, look at Lord Agnew's letter of 10 December, please, which is INQ000585972.

And whilst that's being displayed, the letter itself, you tell us about this -- sorry, I will give the INQ again: 000585972.

Sorry, I think I've given you a rogue reference.

It's INQ000477870. And apologies to Lawrence. INQ000477870.

Thank you.

We can see, this is a letter that you have been provided with from Lord Agnew to Baroness Harding. You tell us in your witness statement, just whilst you're looking at this, that -- of this letter:

"... with Baroness Harding outlining Lord Agnew's significant concerns about Test and Trace's governance and how it was using public money. Lord Agnew believed the previously agreed £150 million spending controls should be reviewed and that they should consider freezing approval on long-term contracts until a forecast and an outline of the governance structure was further developed."

And so we can see Lord Agnew's concerns here. Are you able to help us then? Why were ministers being asked to approve such significant sums of spending at such short notice, and why were these spending decisions not subject to greater scrutiny?

A. The question about notice is, I think, difficult for me to answer. That was the Department of Health and Social Care and NHS Test and Trace making these requests. I think I can only say what I said before, in terms of the Treasury's approach. We had, I should say, in

October 2020, given ministers advice suggesting that we should pause on our approval of the increase in testing, because there was a risk that there was wasted capacity and the use of the tests was not delivering the best possible outcomes in terms of economic outcomes, but ministers chose not -- they didn't agree with that advice, and said that instead we should work on the impact.

So I think this most kind of a consistent, a consistent concern, but one that had to be balanced against what were very difficult circumstances, and particularly, I think it was a lot of competition for the acquisition of the tests, and we were also, in terms of mass testing, which this sort of level of testing enabled, there was very strong evidence of the potential benefits from a health perspective but therefore an economic perspective of being able to identify, you know, as many cases in the community as possible.

Q. Thank you. Now, I'd headlined when we started together that one of the topics will be inequalities. I think as we've dealt with the evidence, I've weaved those in and I've asked the relevant questions I wanted to around inequalities. And again, you've addressed it within the statement, but is there anything further you'd wish to say in respect of inequalities?

A. So I think a couple of things that are in the documents that we've disclosed with respect to this module. The first point I should make is the one I've already made, which is generally where the Treasury is engaged in spending control and the approval of spending proposals, it's for the department responsible for a programme to produce the equalities analysis.

We did provide the Chancellor, as he notes, as Mr Sunak notes in his statement, with periodic updates on the equalities impact of the pandemic in general, and there was some advice that we gave him, which is part of the disclosures for this module, about the strategy for the winter, which noted the differential impacts by different protected characteristics of the economic impacts of the pandemic but also the restrictions.

We also, where, for example, we approved the pilot of the Test and Trace Support System, the Test and Trace Support Payments in the north west, noted the equalities analysis produced by the Department of Health and Social Care. So we did keep it in mind, and indeed it was one of the driving factors between the Treasury's -- the Treasury's view on, for example, the reopening of different sectors was the equalities characteristics of the people particularly affected, in, say, retail or hospitality.

Q. Thank you. Mr York-Smith, we thank the Treasury for this six pages of lessons learning that's within this statement. The statement will be published, the details -- and sets those out.

I'm afraid my time with you is now up so I'm going to turn to the Core Participants for them to ask their questions, please. Thank you.

LADY HALLETT: Mr Jacobs.

Mr Jacobs is right down the end.

Questions from MR JACOBS

MR JACOBS: Good morning. I have a few questions on behalf of Trades Union Congress. Starting, if I may, with the issue of loss of income as a disincentive to self-isolation, and starting, really, with the basic point. In January 2021, a food manufacturing worker described to the GMB union that at their factory, "most of the workers here work for £9.36 per hour, living from week to week just managing to pay their bills without much extra".

Do you think that in the pandemic the Treasury recognised that for workers in that position, two weeks of lost pay would be a powerful disincentive to self-isolate?

A. I think, as I've said in response to some of the earlier questions, the Treasury did provide advice on the

economic impacts of the pandemic, and did provide advice about the characteristics of people who might benefit from the Test and Trace Support Payment, but the decisions about the appropriate level of the payment is one for ministers which I can't --

Q. Sorry, my question wasn't so much whether advice was provided. I'm aware that advice was provided. But was the prevailing view in the Treasury, did it acknowledge that two weeks' of lost pay for people on low income would be a disincentive to self-isolation?

A. I think, as a civil servant, my job is to advise rather than have a prevailing view. So I'm afraid I can't add to what I've said.

Q. I'll try putting it in a slightly different way. As you're providing advice, as your colleagues are providing advice to the Chancellor, is there a sense that the reluctance to provide financial support, the reluctance, apparently, to acknowledge that financial support, or lack of, would be a disincentive to self-isolation, just flies in the face of reality for people working, for example, in a food processing factory?

A. I don't think I can add to what I've already said, which is of course we advised on the impact, but it's for ministers to decide.

Q. I'll try once more. I am going to suggest, actually, that you can provide an answer, because the Treasury officials are entitled to have a sense of whether the options taken fly in the face of the reality for people on the ground of the reality of the advice given?

A. I'm afraid I'll have to disagree. Our role is to advise. Ministers decide.

LADY HALLETT: You've given it your best shot, Mr Jacobs. Move on.

MR JACOBS: I have. I'll move on to the next issue, which is the accessibility of the Test and Trace Support Payment Scheme.

A Covid-O paper in December 2020 described that the application process was too complex. So an individual had to find the relevant authority, find the criteria applied by that authority, find the forms, find what that particular authority required by way of evidence and provide it.

Was that recognised by the Treasury to be a problem with a local-authority-delivered scheme for support for self-isolation?

A. The Treasury was concerned about the delivery of the scheme through the -- throughout the -- its development and its implementation. I do think -- and this was set out in our advice to the Chancellor -- that

a local-authority-led scheme was the best option to deliver, because local authorities, for example, had existing legal powers to make payments to individuals. They had access to the same data as the Department for Work and Pensions, about people's benefit entitlement and about their incomes through realtime information.

But, clearly, the fact that it was -- the administration was complicated affected the take-up and the take-up was lower than we would hope.

Q. And does it really come to the point that it was too complex to achieve its objective, which was to incentivise or support self-isolation?

A. I can't say whether it was too complex, because it would depend what the alternatives were. As we saw with the economic -- the direct economic support schemes, it was necessary for the Self-Employed Income Support Scheme for people to make a claim, because it is not possible for the government to make a payment to someone without having their information. So the people who are in the benefit system, the DWP, can make payments. There were reasons that it wasn't possible for DWP to make these payments but for people who were not in the benefits system, the government required some information from people in the first place in order to make a payment to them. So, you know, HMRC had to -- there was an

application process for that, so I think it was an inevitability that there was an application process involved in this, simply because the government doesn't hold the information in order to make direct payments to individuals.

Q. On the observation that sort of assessing relative complexity depends on the alternatives, do you think that the alternative of Statutory Sick Pay and expanding it if necessary temporarily, would avoid some of that complexity of a novel and locally-administered scheme?

A. So it would be a decision for ministers so I don't want to speculate too much, but I think the types of advice -- the types of factors that I would want to have in advice to them is that Statutory Sick Pay is paid by employers, therefore can only benefit those people who were in employment, which doesn't capture the entire group that this policy was concerned with.

There is also, therefore, a cost to employers, and it has to be seen within the system of whether people, the level of Statutory Sick Pay would be higher than the level of income that someone would get from employment, recognising the variety of employments people have.

Q. So clearly, as with all these issues, more than one consideration, and clearly Statutory Sick Pay can't be the complete answer, but would utilising that existing

scheme address the accessibility problem and the complexity problem? Because it's a scheme that everyone knows, it's via employers, et cetera.

LADY HALLETT: Well, not for those who aren't in work, I think was the point Mr York-Smith was making.

A. Yes.

MR JACOBS: No, of course.

A. It's a different scheme and ministers would have -- you know, it would be for ministers to decide whether they wanted to change Statutory Sick Pay. It has a -- there are sets of people that wouldn't benefit that did benefit from the Test and Trace Support Payments.

Q. Yes. Final point, which is perhaps linked with the complexity issue, is: TUC research found very low levels of awareness of the scheme on a survey, finding only one in five workers were even aware it existed.

Is your impression from your perspective in the Treasury that that too was a feature of it being a locally administered scheme?

A. I don't think I can take a view on that, because I don't know -- yeah, I don't think I can take a view on that. I guess the responsibility for publicising it would be for the department that was responsible for it. There were a large number of locally administered schemes for businesses and individuals and there continue to be

locally administered welfare support schemes. I think it's incumbent on everyone to promote these schemes, and I think it might be something that your organisation might promote in future to your members.

MR JACOBS: It certainly did reference it once or twice.

But I think I've used my time, my Lady. Thank you very much.

LADY HALLETT: Thank you, Mr Jacobs.

Mr Thomas. Mr Thomas is over there.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good morning, Mr York-Smith. My name is Leslie Thomas and I'm representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

Just before I get into my questions, just to be clear, so in the Treasury you were providing advice, you were not making decisions. Yes?

A. Yes.

Q. Okay. So, with that in mind, let me ask you this, and I'm interested in the advice you were given, was the level of Statutory Sick Pay considered sufficient to enable low income and ethnic minority workers, who were statistically more likely to be in precarious employment, to comply with the self-isolation requirements? What was the advice?

A. The advice was not -- the decision about whether

something was sufficient was for ministers.

Q. That wasn't what I asked you.

A. Our advice --

LADY HALLETT: Let him finish, Mr Thomas, please.

A. Our advice noted the evidence on Statutory Sick Pay, including how it compared to the system in other countries, and that is what our advice -- and -- therefore ministers could take a judgement.

PROFESSOR THOMAS: Sorry, what was the advice? You went around in a circle.

A. No, I said that our advice about whether ministers wanted to make a change to Statutory Sick Pay included a reference to the level of Statutory Sick Pay compared to other countries.

Q. Sorry, it may just be me being slow, but what was the advice in relation to whether ethnic minority workers would be able to comply, given the self-isolation rules? What was the advice?

A. I can't really add to what I've said about what the advice was, which was the advice, when we were asked about making changes to Statutory Sick Pay in March 2020, noted the -- noted the cost to employers of that, the impact on individuals gaining eligibility to it. When it came to advice about self-isolation, we didn't provide advice about self-isolation until it was

in response to a request from the Department of Health -- the Prime Minister and the Department of Health and Social Care in the summer of 2020.

Q. Let me move on.

Financial support and inequality. That's the next theme. And again, I'm just concentrating on the advice, not decisions, that you gave, and the Treasury gave.

So the question is this: what role did community leaders or representative groups of ethnic minorities play in the consultation process for financial support schemes like the Test and Trace Support Payment Scheme? So what role did they play?

A. The Treasury did not consult on the Test and Trace Support Payment because it was not a Treasury policy, so I'm afraid I can't answer what consultation was done by the Department of Health and Social Care.

Q. All right.

Moving on. I want to look at data. Did the Treasury gather disaggregated data to assess how ethnic minority and low-income communities were impacted by the test, trace and isolate measures? And if so, how was this data used to adjust policy in real time during the pandemic?

A. We, as I have said in answer to one of the previous questions, the Treasury provided advice to the

Chancellor in the summer of 2020, which noted the impact on particular groups of the pandemic measures in a general sense, and they influenced, for example, the Treasury's involvement in the reopening of sectors where employment was particularly heavy -- heavily from certain groups, including people from an ethnic minority background.

In terms of adjusting the policies, like I say, the policy of test, trace and isolate was one for the Department of Health and Social Care; the Treasury's role was about approving the funding for that programme.

Q. I want to be forward looking, and look at lessons that could be learned, and recommendations. How can future funding frameworks better support low income and precarious workers, who are disproportionately from ethnic minority backgrounds, to safely comply with public health requirements like self-isolation? So what would be the advice, having learned lessons from the last pandemic? Help us.

A. I think it would depend on what the -- I think it would very much depend on the circumstances, what the health restrictions were, what the wider economic support was.

And I think we have definitely learnt some lessons about being able to flush out different views between different departments more quickly, the trade-offs with

other economic support and the interaction of, for example, income support through employers from the -- for the furlough scheme or an equivalent, with specific support for those people who were unable to access that support. So I think there are a number of lessons to be learnt.

Q. Finally this: would you recommend automatic eligibility mechanisms or enhanced payment sick schemes, entitlements, to remove financial disincentives to isolate? Would that be part of the advice?

A. I think, as I just said, it would depend on the circumstances. So we would have to tailor the advice that we gave and the schemes to the circumstances of a future pandemic. And then, of course, it would be for ministers to decide precisely what combination of things they wanted to go for.

PROFESSOR THOMAS: Thank you, Mr York-Smith.

LADY HALLETT: Thank you Mr Thomas.

Ms Munroe, who is just there.

Questions from MS MUNROE KC

MS MUNROE: Good morning, Mr York-Smith.

My name is Allison Munroe. I ask questions on behalf of the Covid Bereaved Families for Justice UK. I have just two questions, Mr York-Smith, but given your answers to Mr Jacobs's first questions, I anticipate

what your answers may be but we'll see how we get on.

Effectively, in February of 2020, the Treasury officials are advising on a budget packet, aren't you, to tackle Covid for the March 2020 Covid budget?

You've been taken through Statutory Sick Pay, and that's what I want to concentrate on. In particular, there were some minor changes to Statutory Sick Pay in the Covid budget, but this did not include expanding SSP to self-employed, nor did it include an increase in the amount of Statutory Sick Pay.

Now, my question, first question, is this: why were those measures not introduced to provide financial support and other assistance to enable those such as the self-employed, who were required to shield or isolate, to stay at home? And I bear in mind what you say, that the Treasury advises, ministers decide. But it was -- part of the consideration of your advice was about SSP and extending it to the self-employed.

A. If I could put it in context, though, when the measures were developed for 11 March, there was not at that point any requirement for anyone to isolate, and when advising the Chancellor, the Chancellor's objectives there were to try -- and the understanding of the virus and its impact was very, very different at the end of February to even by the middle of March.

So when advising the Chancellor on that, his objectives were to try to deal with what he perceived at that point to be some of the impacts of Covid, where I think the belief at the time was that -- and the reason that there was a change to Statutory Sick Pay, was that we were unaware of the seriousness of the virus, and therefore that there would be lots of people who would have a two-week period where they had to stay at home because they were a little bit sick.

So that was the context in which that decision was made. The requirement to isolate and the closure of sectors didn't come until after that point.

Q. But the Treasury officials did flag up, didn't they, that an increase in SSP was one of the measures that potentially was viable, but it had the risk to business? When was that flagged up, then?

A. That was after the budget.

Q. Right.

A. So that was -- so the budget was on 11 March. The documents that we looked at earlier were from 19 March, and they were in the context of a package of measures which is intended to address the economic consequences of closing sectors and asking people to stay at home. So that was specifically about providing businesses with money to pay their staff's wages so that they didn't

have to lay them off, but also recognising that some people would become unemployed and therefore increasing the generosity of the welfare system.

Q. Thank you.

My second question is, then, by August of 2020, and bearing in mind you were taken this morning to the SAGE advice which you said wasn't particularly widely known in the Treasury department, but in answer to my Lady you said the principle was, did the Treasury recognise by August 2020 that unless people were supported to enable them to isolate, policies and isolation simply weren't going to work or not going to be as effective as they could be?

A. In August 2020 we were providing advice on what became the Test and Trace Support Payment. So yes.

MS MUNROE: Thank you very much.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Munroe.

I think I'm going to be consoled by the fact, Mr York-Smith, your knowledge of figures is extraordinary, your ability to recall them. Thank you very much indeed for the help that you and your colleagues in the Treasury have given to the Inquiry in providing the witness statement and all the information contained therein, and for your help giving evidence

today. Thank you.

I shall return at 11.35.

MS CARTWRIGHT: Thank you.

(11.17 am)

(A short break)

(11.35 am)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Thank you.

Could I ask, please, for Ms Daniels to stand, please, and take the oath. Thank you.

MS JO-ANNE DANIELS (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Could you please give the Inquiry your full name.

A. Jo-Anne Therese Daniels.

Q. And can I check, is it Miss or Mrs?

A. Miss.

Q. Ms Daniels, can we, first of all, identify the corporate witness statement that you have provided, if we can go to page 169, please. We see your signature and the statement dated 3 April of this year. And can I ask you, are the contents of that statement true to the best of your knowledge and belief?

A. They are, yes.

Q. And perhaps if we identify the corporate organisation in

respect of which this statement is provided, is it right it's provided to give the context from the Health and Social Services Group?

A. It is, yes.

Q. Thank you. Can we, then, first of all, start with identifying you and why you are the individual speaking to this corporate statement.

It's right, isn't it, that in April 2020 you were appointed as the director of Test, Trace, Protect?

A. Yes, that's correct.

Q. And I think there is one correction in your statement which is in the end date of that role, and if we, perhaps, display paragraph 7, which is page 3.

I think you identify in your statement that you held the role from April 2020 until 3 April 2024. I think that's, in fact, incorrect. I think, is the end date of you being in that role 31 March 2022?

A. That's correct, yes.

Q. So save for that correction, everything else is correct, is that --

A. It is.

Q. Thank you. And let's, then, look at your background, please, just to understand that role you were in. I think you tell us that between January of 2020 and June of 2022, you held the position also as being

director of Mental Health, Vulnerable Groups and NHS Governance?
A. I did, yes.
Q. Thank you. And I think if we take things to the current day, you currently work with Cardiff Council as part of a collaborative agreement with the Welsh Government and have been since 30 April 2024?
A. Yes, that's right.
Q. And before that date you were the interim director general for education, social justice and the Welsh language?
A. I was, yes.
Q. And you'd held that position from 1 April 2022?
A. Yes, that's correct.
Q. Thank you. Now, again, we've already heard some evidence about the group, but can we just make sure that there's a good understanding about the group and how it fits together with the decision making in the Welsh Government. It's right, isn't it, that the Health and Social Services Group provide strategic leadership and oversight of the NHS in Wales?
A. It does.
Q. And it's the conduit between the NHS in Wales and the Minister and Deputy Minister for Health and Social Services?

A. Yes, that's correct.
Q. Thank you. And it's right, isn't it, that the Welsh Government is responsible for social care policy in Wales and the group leads on engagement with the local authority, social services directors and the relevant ministers?
A. It does, yes.
Q. And as we've already identified, during the pandemic, the structure of the pandemic expanded to create the Test, Trace, Protect directorate?
A. It did, yes.
Q. And you were in that significant role as the director of Test, Trace, Protect?
A. Yes, I was.
Q. Thank you. Now, plainly, a huge amount of work has gone into the statement that deals with the involvement throughout the pandemic, and with the time I have with you, it's not going to be able to establish all of the chronology, but the statement will be published. But with your assistance, there's certain topics or themes that I'd just like your assistance to perhaps see if you can expand any further to that which you say within the witness statement.
And the first topic on which I'd like your assistance, because it's going to become relevant as to

what you know is a live issue, in particular for the Covid Bereaved Families for Justice Cymru, on the issue of asymptomatic transmission and testing.
So can we together identify the sources of advice for the group and then that informs government, please. Because you touch upon it in your witness statement. If we perhaps start, first of all, with identifying who was the decision makers.
So if we turn to paragraph 24, please, of your witness statement. Thank you.
If we then move down, please, you identify that essentially cabinet was the main decision-making body within the Welsh Government throughout the pandemic and that Test, Trace, Protect would be discussed at cabinet, and that matters in relation to testing and contact tracing sat largely under the remit and responsibility of the Minister for Health and Social Services who we'll hear from this afternoon, who made decisions in relation to the Welsh Government's Test, Trace, Protect policy.
A. That's correct, yes.
Q. Can you assist, then, when you were in the role of the Test, Trace, Protect group, how did that work practically during that time from your being in the role, please, to inform decision making?
A. So advice was presented to ministers in the form of

ministerial advice papers which set out the matter for decision, the evidence and arguments relating to that decision, and then the recommendation of officials. Alongside those formal ministerial advice submissions, we also had regular meetings with ministers throughout the pandemic period.
Q. Thank you. Can we then look at some of the paragraphs just on the issue of the flow of scientific advice, please and can we move to your paragraph 100, please, which is internal page 30. Thank you.
You detail that advice to support the development of Test, Trace, Protect was primarily provided by Public Health Wales, the Welsh Government's Technical Advisory Cell and Technical Advisory Group and UK-wide structures that we were part of, for example the Testing Initiatives Evaluation Board. And you say that Test, Trace, Protect also developed specific forums for discussion and debate on clinical and scientific evidence.
And so can I be clear, please, about those forums for discussion and debate, please, in respect of scientific evidence. And if it helps, I think it's going to be most significant linked to the issue of asymptomatic transmission and testing, please.
A. So the two groups that I was referring to here was the

virology and testing subgroup of the Technical Advisory Cell which was established, I think, in June or July 2020, and then subsequently I think it was in November or December 2020 we set up the Testing and Clinical Advisory Board.

Q. Thank you, and to see that in context, if we perhaps move to paragraph 103 on the next page, you identify, as you've just said, the Virology and Testing Technical Advisory Cell, the Testing Clinical Advisory Prioritisation Group, which I think you just mentioned, but also the International Intelligence Technical Advisory Cell, and can I ask you, in respect of that International Intelligence Technical Advisory Cell, can you tell us in a little more detail about that and how it worked in practice, please.

A. Thank you.

This group wasn't specifically dedicated to testing or tracing, it was a broader group that was looking at international evidence in relation to Covid and then feeding that into the discussions and the debates within the Technical Advisory Group and Technical Advisory Cell.

Q. Thank you.

Can we please then look at what's said about other sources at 114, please, which on page 34.

You detail in paragraph 114:

"The four nations approach to the National Testing Programme also meant that the Health and Social Services Group had access to evidence, research, evaluations and perspectives from the wider academic, scientific and clinical community. This enhanced the range of sources of advice to support policy and decision-making alongside the structures for Wales. Evaluation studies and assessments of new testing technology were a significant component of the UK testing programme."

Now, can I ask you, then, in respect of then academic literature and the like, how did that operate?

And again, in the context of asymptomatic transmission, we know that the decision making in respect of Wales and the testing for asymptomatic transmission came in in the May of 2020, but there's -- we've already heard some evidence about the knowledge and what was in academic literature about that developing need to test workers in particular, healthcare workers, for asymptomatic transmission, and I think you'll be aware that one of the concerns is the delay with introducing that testing.

Are you able to help us as to how the wider academic literature was being considered by the group and the government on the issue of asymptomatic testing and

transmission?

A. So the groups that I'm referring to in this paragraph were predominantly concerned with new testing technologies, and were groups that we were part of in the latter part of 2020 and into 2021.

In terms of the advice on asymptomatic testing in the early stage of the pandemic, so, as you say, in the sort of March, April, May period, that advice would have come almost exclusively from Public Health Wales, from the Technical Advisory Cell and, of course, from SAGE.

Q. Thank you.

Thank you. That can be removed, please.

Can we then move to another topic that you identify linked to something perhaps that may have been informed by advice.

Can we turn to your paragraph 118, please, which is at page 35.

You've given a clarification on earlier evidence that the Inquiry has heard on the issue of herd immunity, and you say this at paragraph 118:

"As far as I am aware, no steps were taken by the Health and Social Services Group in this early phase of this pandemic to consider or implement a strategy consistent with furthering '[herd] immunity'."

You then reference Mr Drakeford's Module [2B]

statement, which said:

"Discussion of herd immunity could be found in newspapers and in scientific community consideration. It was never a practical proposition in Wales and never proposed as such to the Welsh Cabinet."

And you say this:

"I am not aware of any discussion or conversation during the subsequent or remaining period of the pandemic relating to herd immunity involving [yourself] or anyone else from the Test, Trace, Protect team."

A. That's correct, yeah.

Q. Thank you.

Now I'm going to come on, please, to ask you if you can assist us any further than what you say in your witness statement about the decision on 12 March to stop testing and contact tracing in Wales, which I think you know is, again, another issue of concern to the Covid Bereaved Families for Justice Cymru.

If we turn to your paragraph 124, please, which is where you start telling us ...

At page 36, please, paragraph 124. Thank you.

We can see the decision of the UK Government on 13 March 2020 to end community testing, the reference to the SAGE advice, and essentially, we follow through that that also is the position adopted by the Welsh

Government.

And so, appreciating that you were not in the role until the April of 2020, are you able to assist us any more as to around the decision making that led to a particular decision in Wales to stop testing?

A. No, I'm afraid I can't add any more than is set out in the statement.

Q. Okay. But then can we then together identify what testing availability and the laboratory system existed in Wales.

You deal with the different laboratories that existed, and I just want to make sure we've got absolute clarity as to infrastructure, but also availability for testing, particularly, then, as we move to when Wales also had the assistance through the national testing programme of the Lighthouse laboratories.

Now, you tell us in the witness statement -- and if we go to paragraph 65, please, that's at page 19, please -- you say:

"At the beginning of the pandemic, the NHS in Wales had a network of NHS laboratories -- the majority of these were managed by Public Health Wales to deliver pathology testing across the NHS."

Just so we're absolutely clear about capacity and what existed, can you give us a bit more detail, please.

A. So, early in the pandemic, Public Health Wales had developed a test, a PCR test, for Covid-19, and had begun to expand the capacity within their laboratory network. So they expanded testing from being able to test something in the region of 800 samples a day through to, by September 2020, they had capacity for up to 15,000 samples a day.

Q. Can I just pause you there because I want to try to capture essentially numbers of laboratories that existed.

I think you reference that there were 13 laboratories, is that right, in Public Health Wales?

A. So they had a primary laboratory in Cardiff and then they had a number of smaller laboratories across the NHS estate.

Q. Thank you. And -- well, perhaps -- at paragraph 117 you reference the local diagnostic services through 13 laboratories. That's page 35. I just want to make sure we've got complete understanding of capacity in Wales, particularly when there's later analysis of the decision to stop the testing in March of 2020.

So, 13 laboratories. And are they public health laboratories separate to the laboratories that existed in the hospitals?

A. They were Public Health Wales-managed laboratories.

Q. Thank you. And are you able to give us some idea as to the capacity within the laboratories themselves to do PCR testing before the decision to stop testing in March 2020?

A. I don't have that figure, I'm afraid, no, at that point.

Q. Thank you.

LADY HALLETT: Sorry to -- I appreciate you weren't part of the decision itself but just in case anybody misunderstands where the evidence is going, you talked about Public Health Wales expanding the testing from 800 to 15,000 by September, but isn't the plain fact that in March 2020 the reason community testing was ended was because there weren't enough tests to do it around the community and they had to be focused on certain groups? Isn't that your understanding?

A. My understanding from the statements issued at the time was that the focus for testing was intended to be clinical use and diagnostics of particularly patients in hospital with Covid symptoms.

LADY HALLETT: And the end of that sentence is "because there weren't enough tests to carry them out in the community"?

A. I wasn't aware of the testing volumes at that time, so I can't speak personally to that.

LADY HALLETT: Well, we can put it to other witnesses.

Thank you.

A. Thank you.

MS CARTWRIGHT: Can I perhaps just see if you can help us any further about that, just to understand the position on the ground as detailed in your statement. At paragraph 128, please, on page 38 you say that:

"On 16 March 2020, Public Health Wales confirmed 34 new cases had tested positive for Covid-19 ... which brought the total number of confirmed cases to 94 ..."

And that's why I just want to understand, I suspect you're not going to be able to help any further with the answers you've already given to her Ladyship, but in terms of a decision that was taken, was it taken through the perspective of what could have been possible and continued in Wales in March 2020 by way of the available testing capacity and laboratories that existed in Wales?

A. I'm afraid I don't think there's anything more I can add to what's in the statement.

Q. Thank you. And then the same topic of the decision to stop testing and contact tracing. It's clear from everything in your witness statement and that is known, that the approach to contact tracing in Wales throughout the pandemic and pandemic response retained its local feature. So using the local teams to do contact tracing. And can you just perhaps give your overview

about contact tracing and how it operated in Wales?
A. Do you mean throughout the pandemic period or at the initial phase?
Q. Initially what was available in March of 2020, please?
A. So in March 2020 contact tracing was being undertaken by Public Health Wales so it was being undertaken by the one organisation on behalf of the whole of Wales.
I think it was recognised by Public Health Wales that in order to be able to operate at the scale envisaged as part of Test, Trace, Protect that that would not be feasible, and they advocated for a locally-based contact tracing operation which involved local authorities as the primary frontline deliverer of contact tracing services working with health boards and other partners.
Q. Thank you. And in terms of the system or the structure of contact tracing in Wales in March, is it fair to say that it was well established for that local community testing, albeit not of a scale of a pandemic?
A. So Public Health Wales had operated contact tracing in a number of contexts in terms of public health disease outbreaks, for example, I think in the statement it refers to cases of tuberculosis, other infectious diseases that they'd used contact tracing approaches to contain.
Q. Thank you. Can I ask you a question, please, just to

complete the section on the decision to stop testing and tracing in March 2020, just by reference to paragraph 609 of your witness statement, please, which is page 162, if that could be displayed.
Thank you.
You tell us at paragraph 609 about a response plan produced by Public Health Wales that set out the international evidence at the time of writing that report, and it also articulated various networks and fora that Public Health Wales was involved in through which international evidence and experience of responding to the pandemic including test and trace systems that could be shared.
The question is: are you able to assist at all with what advice was also received in January to March 2020 informed by international experiences and best practices, including early widespread testing and contact tracing of asymptomatic individuals and asymptomatic contacts?
A. No, I'm afraid that period is one I can't speak to.
Q. Thank you. And so in terms of identifying the best person to help us with that in the witnesses that are to follow, would that be Mr Gething?
A. Yes, I believe you're also hearing from Robin Howe from Public Health Wales and he may be able to assist.

Q. Thank you very much indeed. And that can be taken down.
Now, if you can then assist me with the next topic, please. That is, please, in respect of if you could help us just to understand, when you're using, then, the available testing infrastructure in Wales, as to how it evolved then to utilising the National Testing Programme and the Lighthouse laboratories, and I'm going to just identify the Lighthouse laboratory that came online in Wales, please.
If we could just display the Lighthouse laboratories map, I'm afraid it's INQ000587450 -- sorry, my eyesight is struggling with that. It's the map of the Lighthouse labs.
It's been shown. Thank you so much.
Now, we can see and we're going to come on to deal with Newport that was opened in October of 2020.
Can you then help us with identifying that date. Was Wales, once it was utilising the National Testing Programme, sending its samples, then, into the national testing Lighthouse labs that existed outside Wales?
A. That's correct. So to a significant extent, Wales started to use the testing capacity within the Lighthouse laboratory network in May of 2020. At that point, samples were being sent to a number of laboratories across the UK under the operational

direction of UK Test and Trace.
Q. Thank you. And in terms of that happening and also you've also got the system of using the local testing labs, did that create any difficulty in terms of the data and the results that was captured? Was -- I think was there a different system relating to the barcodes of the test results?
A. So the digital systems that existed to identify the sample and track the sample through the laboratory networks were different between the Lighthouse lab and Public Health Wales. But the flow of the test results, both to the patient and into the patient's medical records, that flow was, in effect, the same.
Q. It was the same.
A. **(Witness nodded)**.
Q. So was there any issue in terms of the systems of the testing through the different routes in Wales?
A. So the routes were separate in the sense that you had sampling centres linked to a specific laboratory route, so the Lighthouse laboratory route, and then you had separate sampling centres linked to the Public Health Wales laboratory network and you could not switch between the two different routes.
Q. Thank you. Now, in terms of the development and the availability of a laboratory specifically in Wales,

you've told us in the witness statement, essentially, about how the thought was that was going to come online, I think sooner than October 2020 --

A. (Witness nodded).

Q. -- and of the delays in establishing it. Did that have any impact, then, in terms of the availability of testing in Wales that you didn't have your own bespoke Lighthouse laboratory?

A. So the benefit of being part of the Lighthouse Laboratory Network was that we had a share of the tests across the network as a whole. So we were not exclusively confined to the capacity that was available through the Newport lab. So for example, tests taken from sampling sites in North Wales quite often went to Alderley Park because that was the nearest laboratory location. So while the delay in the Newport laboratory being established would have affected the capacity of the Lighthouse Lab Network in totality, it didn't have a specific or disproportionate impact on Wales because we had a share, a Barnett share, so a population equivalent share, of the whole of the Lighthouse laboratory network capacity.

Q. Thank you. And can I ask you, then, in terms of the Barnett share that was then allocated before Newport came online, was there ever any issue that you didn't

have an ability to get the tests back because of capacity at any point after March of 2020, please -- well, April 2020, when the Lighthouse laboratories were available?

A. So, I think I've set out in the statement that during August and September there were capacity constraints within the Lighthouse laboratory network which affected Wales but also England, Scotland and Northern Ireland. So there were particular instances in August and in September when the availability of tests at sampling sites were curtailed in order to prevent a backlog of samples building up within the laboratories.

Q. Thank you. Can I ask you, please, again just by reference to Newport -- can we display your paragraph 173, please, which is at page 49.

Paragraph 173 at page 49, please, of the statement, INQ000587349. Thank you. If that could be expanded.

I just want to check the position relating to the Newport laboratory. Obviously you detail there the ministerial advice and when it was expected for the laboratory to be operational, but it also indicates that after the 12-to-18 month period, it was intended it would be inherited by Wales to form part of Wales's national laboratory infrastructure for the future. And has that taken place for the Newport laboratory?

A. So the Lighthouse lab in IP5 that was operated by PerkinElmer was -- no longer exists, but the Public Health Wales laboratory that was established alongside it, is still operational.

Q. Thank you. And so just help us understand. So PerkinElmer operated the Newport site and why was there a public health laboratory alongside the PerkinElmer laboratory?

A. So initially Public Health Wales -- as you identified at the start, Public Health Wales had a network of laboratories. In order to increase capacity, but in order to also increase the speed with which tests could be processed and results issued to the public, they presented us with a business case to enable them to consolidate their lab capacity at IP5 in Newport. That was in, I think, June or July of 2020. That business case was approved and they developed a larger laboratory at IP5.

At the same time that site was identified by UK Test and Trace as an ideal location for a Lighthouse laboratory. So, from September/October 2020 through, the two labs operated from the same facility.

Q. Thank you. So there's no ambiguity, was it ever intended, as part of what we see in paragraph 173, that essentially the PerkinElmer side of the Lighthouse lab

would then become part of the infrastructure in Wales?

A. I think at the outset it had potentially been considered as an opportunity to benefit from that laboratory set-up, but because it was commercially procured, once that contract ceased, the laboratory equipment and so on, was disassembled.

Q. Thank you.

Can I then ask you, please, about -- again, some of these, we appreciate that the fuller context is within the statement, but can I ask you, then, about the topic of the involvement of Roche and testing, please.

You deal with it at your paragraph 131, please, which is page 38.

And it's just to see if there's any additional assistance you can give us on the expectation that Wales was going to receive a capacity of tests from Roche, which then didn't transpire.

So we can see you detail:

"Expectations on testing capacity ..."

And this is in March 2020:

"... included volumes that were dependent upon negotiations taking place between Public Health Wales and Roche Diagnostic ... Public Health Wales led on the discussion with Roche. An agreement did not subsequently materialise which the Welsh Government

understands was attributed to a miscommunication of Wales' position by the UK Government which was also in negotiation with Roche at the time. Roche subsequently entered an agreement with the [United Kingdom] Government to supply tests for all four nations and Wales was allocated a share of these -- around 900 per day at that time. This was significantly less than had been anticipated from the expected Public Health Wales deal."

And so --

LADY HALLETT: I think -- can we just pause here. This is quite a controversial issue, as I recall, from my time in Cardiff, and I'm not sure the position is yet clear.

So, question: how much can you help, Ms Daniels? Because you're relying here on documents that others have produced.

A. That's correct, I am. And so I can reference to those documents but I can't add beyond what's in them.

LADY HALLETT: I think one of the problems is that Roche don't necessarily agree with other people's positions; is that right?

A. That may be the case, yes.

LADY HALLETT: Question: can I get any further than I got in Cardiff?

MS CARTWRIGHT: No. I will move on then, my Lady.

Can we, then, just on the topic of testing on Immensa and the Immensa samples, please.

Can we display your paragraph 243, please, at page 69.

And you detail, as we move through this section on Immensa and over the page, please, about -- thank you -- highlight paragraph 245.

Essentially it's right, isn't it, that tests from Wales were then being processed at the Immensa laboratory and then there was the issue as to the accuracy of those Immensa samples.

And if we look at 245 you say:

"I was very concerned about the impact of the incorrect reporting on Welsh residents as Welsh tests had been diverted to the Immensa laboratory at that time due to high demand and to alleviate pressure on the Newport lighthouse laboratory where the majority of samples were processed."

You say:

"In early October 2021, analysts in the Welsh Government had noticed that in some parts of Wales, the relationship between case rates and positivity rates was showing an unusual pattern with positivity rates falling more rapidly than would be expected. Analysts tried to investigate by looking at cases by locality and age

group but did not have access to data by laboratory. There was also activity on social media of people reporting that they'd been positive on lateral flow devices, but their PCR test had been negative. Without the data from the laboratory the initial focus centred on lateral flow device accuracy."

So, pausing there, is it fair to say that the laboratory itself didn't identify the issue to you: it was picked up by other routes in Wales relating to the Immensa test?

A. That's correct. So, if I may, and just go back a little, the Immensa lab had been contracted by UKHSA at an earlier point in time. So I think in February/March of 2021. And at that point, Public Health Wales had raised some concerns with UKHSA about the test results and seeming anomalies in the results emerging from that lab.

Those concerns were raised at one of our Test, Trace, Protect programme board meetings. I made contact with UKHSA laboratory colleagues to set out that we were worried about the data emerging from this lab, and we were assured that everything was in order.

The contract with the lab then ended, and a second contract was put in place that covered this September/October period, where, again, it seemed that

there were anomalies in results emerging. And as the paragraph there states, primarily the concern was being raised by individuals receiving positive lateral flow tests and then negative PCR tests and feeling that it just wasn't correct.

Q. Thank you. And are you able to help, when -- was there any sort of issue then taken with the laboratory about why they'd not directly raised this issue, from an audit point of view, and it needed essentially the other routes by where you identified the problem to flag that there was the issue?

A. Yes, so I think the Immensa lab wasn't just utilised for tests coming from Wales; it was also the south west of England. And public health colleagues in the south west of England I think had noted similar discrepancies and discordance in results between lateral flow and PCR tests.

That was raised again with UKHSA, at which point they investigated the lab and found that there were some significant and serious errors, and that a number of false negative results had been issued to members of the public.

Q. Thank you.

Can I ask to be displayed next, please, paragraph 140, which is at page 41, please. Thank you.

And it's where you've helpfully detailed, with another issue that the Inquiry has heard some evidence about, the Cardiff City Stadium testing centre. You say this:

"On 2 April 2020, it was announced that a UK Government-operated drive-through test sampling site was opening at Cardiff City Stadium as part of the UK Testing Programme through arrangements with Deloitte. The opening of this test site had not been communicated before the announcement by the UK Government to Public Health Wales or the Welsh Government. As a result of this, rapid joint working with Public Health Wales and other key partners was required to get the site operational and set up for opening on 7 April."

Can you expand at all about this, because we heard some evidence yesterday from Deloitte's perspective that they understood it was known and certainly there would have been arrangements that had to have been entered into with a local authority. And so can I ensure that we've got the totality of evidence as to what was known by the department, please.

A. Yes. So I think it's important to put into context in this period that the National Testing Programme was very much at, sort of, an embryonic stage, mechanisms for communication between Welsh Government and UK Government

hadn't been formalised in terms of oversight of the National Testing Programme, so I think it's probably fair to say that communications were not optimal.

I don't -- I am aware that Deloitte were in contact with the local authority to discuss the establishment of the site but we've not been able to identify any communications with Welsh Government at that time to suggest that we were aware that the site was going to be established.

Q. Thank you. In terms of that as part of the collaboration that was taking place between you and the UK Government, did that raise any concern, the fact that, essentially, plans were well afoot to establish the a laboratory, a testing centre, sorry, in Cardiff that the relevant organisations within Wales weren't aware of, particularly where health is a devolved matter?

A. So I think it's fair to say at the time, and this period was before I took up post so I wasn't directly involved but I was very aware that it caused some consternation across the department, but I think I'd reflect that this was a period of quite frenetic activity and probably just reflects the speed with which people were trying to roll out and establish sampling sites and build testing capacity.

So I would probably put this down to oversight rather than anything more than that.

Q. Thank you.

Can I now, please, explore with you the topic of asymptomatic testing and transmission, please. And please can we go to your paragraph 167 at page 47, please.

Please bear with me: there's a number of documents that I want to take you to, to explore with you that which you say in paragraph 167. You say this:

"On 16 May 2020, the Minister for Health and Social Services announced that all care home residents and staff were able to access tests on the UK Government portal under the National Testing Programme arrangements."

And you provide a copy of that with your statement.

And then over the page, please, it says:

"This announcement followed new advice from the Scientific Advisory Group for Emergencies on how testing should be deployed in care homes to help reduce transmission into and within care homes, including offering testing to all (asymptomatic as well as symptomatic) care home staff and residents in care homes that reported an incident or outbreak."

And you go on:

"The new approach built on and expanded the existing approach in place."

And then you attach the relevant advice.

But can I then explore with you the fact that it's being headlined on 16 May as "new" by reference to a number of documents, please.

Can we look, first of all, at the 12 May SAGE advice, please, which is INQ000217624, and if we look at page 5 of that paper, please. Thank you. We can see that it references:

"A strong scientific rationale to test all residents, irrespective of whether symptomatic or not, giving strong evidence of asymptomatic transmission in care homes."

Now, the evidence for asymptomatic transmission underpinning this advice was in fact not new and I think there's a large body of source material supporting the SAGE paper that existed from earlier months.

The position I want to ask you about is what we've discussed already in terms of access to scientific advice. The Welsh Government decision makers had access to a lot of evidence of asymptomatic transmission prior to May of 2020, and perhaps if we can look at some examples of that, please.

If we look at INQ000195520, please. This is Public

Health Wales's advice from 10 February 2020. Thank you.

We can see, just on page 1, it details:

"This document summarises the pathway to be initiated following a first presumptive case of 2019-nCov in Wales. It identifies the stages of initial assessment and diagnostic testing ... and to provide reassurance to Welsh Government ..."

If we move within this document, please, to page 4. Thank you.

We can see on page 4 that it summarises the pathway to be initiated following a first presumptive case of Covid-19 in Wales, identifying the stages of initial assessment and diagnostic testing, information flow on receiving a positive result.

And then if we move, I'm sorry, through this paper to the appendix. Thank you.

Again, I think the appendix also identifies the questions around:

"Does the call relate to a potential case (... person with symptoms or asymptomatic contact with confirmed case?) ...

"Are they an asymptomatic contact of a confirmed case?"

Now, again, this is February 2020. And I think also it's that the Diamond Princess cruise ship had

identified asymptomatic transmission at that point, in February 2020.

So can I just ask you to pause there, because otherwise I'm going to be giving you a lot of dates before May. Was there an appreciation by the department and by the government of asymptomatic transmission in the February of 2020?

A. This is -- you're talking about a period before I was in post, so I can't necessarily address the specifics of what was known by individuals at that point. This document in itself I don't think suggests that there was knowledge of asymptomatic transmission. It's reflecting that contacts of positive cases may not have symptoms because they may not be infected.

I think it is fair to say that there was acknowledgement that asymptomatic transmission was possible, as was the case with a number of other respiratory viruses, however in this -- up until much later in the period, I don't think the extent of asymptomatic transmission, nor the potential infectivity of an individual who was asymptomatic, was well understood.

Q. Thank you.

Can we perhaps then just look at advice that was received by Mr Gething, please -- thank you, that can be

removed -- which is INQ000136783, and I want to go into page 48 in that document, please.

So this is the ministerial advice.

And can we move to page 48, please.

I think there may be a problem with the reference to the paragraph. So I'm just going to -- so this is the advice from 14 May but within that advice, and I apologise I can't display it to you at the moment, it identifies that asymptomatic positive individuals could be infectious prior to exhibiting symptoms.

We've also got a statement that's been provided from Public Health Wales. Thank you. Sorry, can we -- just within that, sorry, just to go to, then, paragraph 173 within the statement of Mr Gething please. Thank you.

Thank you. So this is the context, I think, that advice was based on advice provided by the SAGE group -- thank you -- concerning the testing of asymptomatic care home staff and residents.

Thank you.

So essentially there's a body of evidence, it's suggested, that means it should have informed decision making sooner. I appreciate that it's already been addressed by the Welsh Government in their opening as to the position about whether that could have been addressed sooner, but have you anything further you can

add that assists us about whether there should have been a change in the policy before May of 2020 that identified the need for asymptomatic testing, please?

A. So the advice from SAGE that you've displayed and referred to was 12 May. In that advice, SAGE gave a very clear recommendation that there should be asymptomatic testing in care homes of staff and residents.

Subsequent to that, as you've displayed again, on 14 May advice was given to ministers that we should introduce asymptomatic testing in care homes. That advice was approved and agreed by ministers and was then operationalised within two or three days of that decision being taken.

So, upon that SAGE evidence on the 12th, which I think was a significant turning point in terms of the understanding of the risks associated with asymptomatic individuals and their level of potential infectivity, the decision to introduce and implement routine and regular testing within care homes was taken.

Q. Thank you.

Can we then perhaps just look at the ministerial advice from March, please, which is INQ000235863. Thank you. If we move, please, to page 2 of this advice from March. This advice suggests that it was understood that

around a third cases are asymptomatic, and at paragraph 3, it details:

"... the Test, Trace, Protect programme board considered the testing of all asymptomatic as well as symptomatic close contacts but recommended that asymptomatic testing was not implemented due to concerns at the time over PCR testing capacity. There were also concerns about the possible behavioural effects notably the risk that close contacts who test negative, might 'break' their self-isolation ..."

Can I ask you, then, was it a capacity issue rather than the current position of scientific advice that may have also factored into the decision to implement asymptomatic in the May?

A. The May decision on asymptomatic testing in relation to care homes was not constrained by capacity. That decision was driven by the advice of SAGE.

Q. Thank you.

Can we then, please, just clarify, because you are identifying in your statement about this being new, the advice of SAGE in the May, and I just want to question, do you stand by that referencing it as "new" evidence is appropriate in the full context of academic literature that was available in May of 2020 that did indicate there was good evidence of asymptomatic transmission?

A. So in -- there were previous submissions to ministers. I think there was one on April 30 that set out advice on testing in care homes, that certainly did discuss and raise the issue of asymptomatic transmission. However, at that point the best evidence that was available to us was that the asymptomatic transmission that was known and understood did not warrant universal testing in care homes.

As I say, subsequently, SAGE was asked to provide advice, which it did on 12 May, and on the basis of that, further advice was given to ministers with a revised recommendation that asymptomatic testing of staff and residents be introduced.

Q. Thank you.

LADY HALLETT: Accepting that, and accepting that obviously capacity is always a factor, but did people consider the possibility that there was asymptomatic transmission, and therefore the right approach, if one was going to contain this pandemic, was to operate on the basis that there was asymptomatic transmission?

A. So the advice at the time also asked us to consider the potential risks of testing on an asymptomatic basis, in particular that you might get, in periods of low prevalence, a significant number of false positives that would lead to individuals being extracted from the

workplace, which in and of itself could then create harms if you were not able to staff appropriately and safely.

So, whenever testing decisions were being made, there was always a balance of harms that was being considered.

But as I say, in the case of care home testing and asymptomatic testing there, as soon as the evidence pointed conclusively to there being benefits from doing so, we did so.

LADY HALLETT: What was the evidence to suggest the significant number of false positive tests?

A. So there were -- there was evidence from Public Health Wales and from the Technical Advisory Cell, that was subsequently published then, I think, in July there they talked about the most effective use of PCR testing, and there are some tables in that document that set out the potential for false positives in low prevalence environments, and the need to consider whether that, in and of itself, would create more harm.

MS CARTWRIGHT: Thank you.

Can I move on to a new topic, please: the contact tracing app.

Perhaps if we orientate ourselves in your statement for this topic, please, at page 96, paragraph 349.

Thank you.

We know essentially that the app -- so Wales, essentially, tagged on to England's development of their Covid-19 app; is that correct?

A. We considered the possibility of developing a Wales-specific proximity app, but decided for a number of reasons, including the importance of interoperability with England, given the porous nature of the border between England and Wales, that an England and Wales app would be most appropriate.

Q. Thank you. And if we move along to paragraph 353, we see just that you've told us about, the interoperability group discussions on ensuring the usability of that app.

Obviously the full details are in the statement, but I wonder if you're able to help with the perspective on the take-up of the app once it was available. So we know the app was available from 24 September 2020, but we've had now some analysis provided, presented as to the take-up of the app, and I know you've had access to it today, but can I just show you, please, INQ000574818.

That's INQ000574818, and it's internal page 2 where there's a map that identifies -- thank you. If we move to page 2, and if we just expand the map, please. If we expand it a little bit more.

So I'm looking at b, and I know you've had a chance

to look at it, we can see that the uptake in Wales was, almost consistently throughout the whole of Wales, low at the sort of 15-20% rate, and are you able to -- first of all, had you ever been provided with this data, first of all, as to uptake across Wales?

A. So we did have access to the uptake data. I've never seen it presented in this format before, though.

Q. Thank you. And are you able -- and I don't want to, if it is speculation, please don't, but are you able to help us understand why there was such a low uptake of the app in Wales?

A. So I'm not aware of any specific analysis that's been undertaken to explain the differences in uptake, but some reflections that I would offer. Comparisons between England and Wales, it's quite important to use parts of England that are more similar to Wales in terms of their socioeconomic make-up. So that may be something that we would typically look at the north west of England, for example, rather than the generality of England.

I think digital exclusion, it's referenced, actually, in the Public Health Wales response plan that ONS estimates suggest that about 20% of the Welsh population are what they would term digitally excluded. So, again, that may have had an impact on uptake.

I think it's also fair to say that we saw the app as being an adjunct to contact tracing. We tended not to refer to it as a contact tracing app. We tended to refer to it as a proximity app, which may sound pedantic but actually reflected, I think, that we thought it was a useful way of telling people that they may have been in proximity rather than as an instruction, as it were, to isolate in the way that contact tracing was.

And as a consequence, I think it's also fair to say that we didn't promote uptake specifically in Wales beyond the promotional efforts that were made by UK Government.

Q. Thank you. Just three further short questions from me, please.

Thank you. That can be taken down.

Financial support for isolation. We displayed earlier in evidence with another witness the financial support that became available in Wales, initially at the 500 rate and then increased to the 750 rate from the August of 2021.

But can I ask you more broadly, you talk about financial support for isolation. Are you able to assist as to or respond to criticism of the financial support payments which there's a general view that they were not enough, especially for individuals from vulnerable

communities, due to precarious work status, refugee status, or otherwise?

A. So I think we were aware that there were a number of barriers to isolating when people had been asked to do so. Those concerns about the impact of isolation, also, probably, we were concerned were reducing take-up of testing, as well. So we had set in place, right from the outset, the strand of work known as "Protect" to try to support and facilitate people to adhere to isolation.

I think we were clear that the barriers to isolation were largely structural rather than motivational, so by "structural" I'm referring to those socioeconomic challenges that people faced. So we had been advocating for financial support and ministers had been advocating for financial support in their discussions with UK Government for some time, but the October/November was the first point at which we were able to introduce that because we were able to benefit from financial consequentials from the UK Government following the introduction of financial support there.

Q. Thank you. And are you able to give any additional assistance? Wales was unique in increasing the availability up to £750. Did that take much decision making to increase it for the period from the August of 2021 to the January of 2022?

A. So that decision was very closely bound into the decision at that point to remove the requirement to isolate for contacts who were vaccinated or who were under 18. And I think it was well understood that the unvaccinated population at that point in time tended to be those from lower socioeconomic groups, black, Asian, and minority ethnic groups, et cetera, and that they would therefore be disproportionately affected by the continuing need to isolate if they weren't vaccinated, and so the decision was made to provide additional financial support, so the increase of £250.

Q. Thank you. And can I ask you, in respect of the Self-isolation Support Scheme, was there an equality impact assessment for that?

A. So in the advice that was given to ministers in October 2020, there is reference to an equality impact assessment being undertaken, and a summary of the headline conclusions of that equality impact assessment were set out for ministers to consider.

Q. Thank you. And then finally, for my purposes, because my time is nearly up, recommendations. Again, there's a number of paragraphs that deal with lessons learning and recommendation on behalf of the department, but can I ask you, just briefly, about paragraph 630, please, at page 167.

If that can be displayed, thank you.
You say at paragraph 630 that:
"Planning for future preparedness needs to consider the standing capability and scaling up of test, trace and isolate required across the five routes of transmission."
Are you able to assist about what the present state of the standing capability in scaling up is in Wales currently, please?
A. So having left the post in March 2022, I can't speak personally to the current state of preparedness, but a review of public health arrangements was undertaken, and those recommendations are in the process of being implemented and as I understand it, in part, that relates to having standing capacity for contact tracing.
MS CARTWRIGHT: Thank you.
My Lady, those are my questions. Thank you, Ms Daniels.
LADY HALLETT: Thank you.
Mr Thomas, who is over there, that way.
THE WITNESS: Thank you.
Questions from PROFESSOR THOMAS KC
PROFESSOR THOMAS: Sorry.
Good afternoon.
A. Good afternoon.

Q. Let me just give you a little bit of an introduction. My name is Leslie Thomas and I'm representing FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations. I only have a couple of questions for you. But in your witness statement, you say this -- and just forgive me, I just need to quote a little bit of it to you, you say:
"In October 2020, the Welsh Government funded the appointment of dedicated Black and Minority Ethnic public health outreach workers in each health board ... The community outreach workers were focusing on providing support aimed at breaking down barriers preventing Ethnic Minority groups from taking Covid-19 tests, supporting people to self-isolate when necessary, encouraging vaccine uptake and facilitating a two-way communication between organisations and communities. The outreach workers each in each health board also supported engagement work for refugees, asylum seekers and migrant groups. This aimed to maximise outreach for Test, Trace, Protect and widen engagement on all matters related to prevention or further Covid-19-based deaths. This was based on learning from international models for mobilising community outreach like the Barefoot Workers in India."
And you say a suite of 28 different languages in

different accessible formats were developed to communicate Test, Trace, Protect to black and Asian and minority ethnic people and vulnerable groups in Wales.
My question is this: how successful do you consider that the outreach plan was, given all of that you were doing?
A. So we didn't undertake a formal evaluation of those -- of the work that those individuals undertook, but we did have feedback at our regular TTP oversight group meetings, where health board colleagues, local authority colleagues, would talk to us about activities that were being undertaken locally and regionally. And we were able also to gather case studies of good practice, effective practice, across testing and contact tracing.
Q. Given all that you were doing, were you ever consulted by the other UK governments about the potential utility of your outreach plan?
A. Oh, that's an interesting question.
No, I don't think we were. I think, in my statement I've reflected that some of the UK arrangements for discussion on tracing or the protect element weren't as formalised as they were for testing, because of the National Testing Programme. But we did meet with colleagues fairly regularly on an informal basis to exchange experiences, evidence, emerging practice. It's

possible that during those meetings this was discussed, but I personally wasn't involved in any.
PROFESSOR THOMAS: Thank you.
Thank you, my Lady.
LADY HALLETT: Thank you, Mr Thomas.
Ms Munroe, who is just there.
Questions from MS MUNROE KC
MS MUNROE: Thank you, my Lady.
Good afternoon, Ms Daniels. My name is Allison Munroe and I represent Covid Bereaved Families for Justice UK. Just two questions.
They arise out of your discussion in your statement on equality assessments, where you set out that there were equality impact assessments, and these were continually reviewed as Test, Trace, Protect developed and evolved in respect of certain groups from the population with protected characteristics under the Equality Act.
However, why were there delays in getting National Testing Programme advice and support materials to certain groups, to certain vulnerable groups in the population?
A. I'm not aware that there were particular delays in information being made available to those vulnerable groups. The materials that we produced to provide

the -- the communication materials that we produced for Test, Trace, Protect were always translated into multiple languages, and we had a number of forums and groups that we were engaged with that we used to disseminate information. So the Race Equality Forum, disability forums, just as two examples.

Q. But in that paragraph where you are discussing equality impact asset management, you say:

"I recognise there were at times delays in providing materials to advise and support for some groups."

You don't name which groups they are but you acknowledge that there were delays. So why were there those delays?

A. There may have been delays because of requirements for translation, for example. But I'm not aware of significant delays beyond those operational impacts that there might have been.

Q. And are you able to be more specific in terms of which particular groups you had in mind when you say "particular or certain vulnerable groups"?

A. No, I'm afraid I can't expand on the statement.

Q. The second question is this: bearing in mind your answer just now, and what you've said in your statement, what should and could have been done to ensure that all groups that were described as vulnerable and those with

protected characteristics received information in a timely fashion, so there wasn't any -- whoever it was for, and whatever the delay was, there shouldn't have been any, and what should have been done to alleviate that?

A. So the feedback that we had from our communications was that we achieved quite significant reach with our communications. We were, I think, very fortunate to be able to use our local authority colleagues to disseminate information beyond the sort of traditional channels that government would be able to use.

I think I would reflect on the importance of doing that, that sometimes national campaigns, while they are often very, very effective, actually utilising local communication channels, could be of more significant value in being able to reach out to groups that perhaps sometimes are lesser heard.

MS MUNROE: Thank you very much, Ms Daniels, it's not the first time we've heard about the importance of local groups. Thank you.

LADY HALLETT: Thank you, Ms Munroe.

That completes our questions for you, Ms Daniels. Thank you very much indeed for the help that you've given. I mean, having left, was it your former colleagues who prepared the very full witness statement?

A. Myself and my former colleagues.

LADY HALLETT: Well, thank you to all of you. Obviously it was quite some achievement to prepare such a detailed statement, so I promise you we will be taking into account the written evidence as well as your oral evidence.

THE WITNESS: Thank you very much.

LADY HALLETT: Thank you for your help.

I shall return at 1.45.

MS CARTWRIGHT: Thank you, my Lady.

(12.47 pm)

(The Short Adjournment)

(1.45 pm)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Thank you.

My Lady, please could I call Mr Gething, who appears over the link. Thank you.

LADY HALLETT: Can you see and hear us, Mr Gething?

THE WITNESS: I can hear you and see you on the screen indeed.

LADY HALLETT: And if Ms Cartwright can speak because the last time the person on the link could hear me but not hear her.

MS CARTWRIGHT: Good afternoon, Mr Gething, can you see and hear me?

THE WITNESS: I can indeed.

MS CARTWRIGHT: Thank you very much. If I can ask the witness to be sworn, please. Thank you.

MR VAUGHAN GETHING (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Thank you.

Could I ask you, please, to give your full name to the Inquiry.

A. My full name is Humphrey Vaughan ap David Gething. I'm commonly known as Vaughan Gething.

Q. Mr Gething, can we, please, identify your Module 7 witness statement. Hopefully you've got a copy in front of you there?

A. I do.

Q. Thank you. It's dated 20 March 2025, and can I take you to internal page 103, please. Thank you. And can I ask you to confirm, are the contents of that statement true to the best of your knowledge and belief?

A. I believe there are. If there are typographical errors, I'll be happy to correct them during the course of the evidence.

Q. Thank you. And, in fact, Mr Gething, this is Module 7 and in fact that statement represents your seventh witness statement you've provided to the Inquiry, and it's right, isn't it, also, that this is now your fourth

appearance before the Inquiry giving evidence in respect of different modules, as you'd previously given evidence on 20 November, 11 March 2024, and 4 July 2023?
A. That's right, yes.
Q. Thank you. I appreciate, Mr Gething, you've previously been identified and your background also, but it's right, isn't it, that during the pandemic you were acting in the role of the Minister for Health and Social Services and the Minister for Economy?
A. That's correct.
Q. Thank you. And it's in respect of that role that I'll be asking questions, but perhaps, again, just to give some context by way of your background, could I ask you, Mr Gething, just to give your relevant background prior to March of 2020 by way of your political experience, please.
A. I was previously a Cardiff councillor from 2004 to 2008. I was elected to the Senedd in May 2011. I then was appointed to the government in 2013, as a deputy minister. I joined the cabinet as the then Cabinet Secretary of State for Health, Wellbeing and Sport in 2016 after the Senedd elections. I can give you a fuller CV but it's covered in my statement at paragraphs 6 and 7.
Q. No. Thank you very much indeed.

I appreciate a number of these topics have been previously touched upon in other modules, but can I ask you and capture from your perspective, bearing in mind you had the ministerial decision-making role, as to where you accessed your scientific advice from, particularly in respect of the pandemic and decisions relating to Test, Trace, Protect, please?
A. So we have two scientific advisers for health, and I understand you've got a statement from Rob Orford, who was the chief scientific adviser for health at the time. That's in addition to the structures that are created, so the Technical Advisory Cell and the Technical Advisory Group, and they overlap a little. So they provide a report looking at the science, they synthesise, for ministers and others, lots of advice internationally, including from a UK perspective around SAGE, Rob Orford or Chris (inaudible) I think were observers at various points in time on SAGE as well, and participants, and that's all allied to and taken account of together with the advice we get from the Chief Medical Officer. I understand there's a distinction between medical and public health advice in science, buts that's the advice that's primarily coming towards ministers for us to consider.
Q. Thank you.

LADY HALLETT: Mr Gething, I'm sorry to interrupt. The stenographer is having trouble. It may be something to do with using the link but if you could speak more slowly I think it might help her capture every word.
MS CARTWRIGHT: Thank you.
THE WITNESS: I will try to, my Lady.
MS CARTWRIGHT: I don't know whether it is when you move your head to the side, Mr Gething, that some of your answers drop out, so I don't know whether the microphone that amplifies you -- maybe if you keep a fixed position towards that, it may help.
THE WITNESS: I shall try.
Q. Thank you.
Can you assist us, then, in particular -- because I'm going to explore with you, please, the decision that was made, essentially by the Welsh Government, in line with the UK Government, on 13 March, to essentially stop all testing in Wales but also to stop contact tracing.
Module 7 wishes to explore this because plainly infrastructure and capabilities potentially differs across the four nations, so I want to ask first of all, in respect of the contain to delay, your full capture, please, of what was considered at that time, please. And can we move, then, to your paragraph 104, where we deal with the decision making.

It's at page 23, paragraph 104, please.
A. So things had moved quite rapidly in the previous two weeks, where we started to have our first cases being reported in Wales and obviously the case numbers growing in the UK. We'd agreed a Coronavirus: action plan across the four nations that had these different phases, including contain and then delay.
Q. Can just ask you to slow down a bit, Mr Gething. I think you're speeding up again. Thank you.
A. Sorry. So the UK Government decides on 13 March that it will cease community testing because it has sustained community transmission.
The agreed move from contain to delay talks about the number of different phases in trying to deal with the pandemic. In Wales, we carried on with community testing for a few days more, which I think I cover in the next couple of paragraphs in my statement. But I think it's 13 March when I announced that the NHS is going to cease a range of standard activity. So it's quite an important day, with lots of decisions made about how much more serious the pandemic is.
And this is really driven by the fact that the -- that Covid-19 is now established in the UK and spreading. It's at a slightly different point, though. So, essentially, most of the importations taking place,

largely in the south east, not just in the south east, so it's moving essentially west and north across the UK. The importations in Wales largely took place, actually, from the February half term, when people were returning from Europe so we had our own direct import into Wales for the virus, and that's what its taking place.

So paragraph 104 of my statement covers both what's said at the meeting on 13 March, the COBR meeting, and the move from contain to delay. I also set out here in the notes that we stopped community testing in Wales on 17 March, based on Public Health Wales' advice, but, as I've just said, it's the day when I announced that a number of measures will be taken in the NHS to allow the NHS to get ready for what we believe is coming.

Q. Thank you.

Can I then capture from your perspective, because obviously you were involved in that decision and the UK COBR meeting, but can you give us your perspective of what existed by way of testing capacity and capability in Wales as at 13 March, please, of 2020?

A. I think we had hundreds of tests available each day at the time, as opposed to thousands and thousands. I can't remember but I'm sure there's a chronology to correct the understanding. But at that point, for the contact tracing that we're still doing with community

testing, we had enough tests and the tests at the front door of the health service.

The move from contain to delay and then, in Wales, the ending of community testing is really about the progress of the virus. It's about the fact that you're in a position where the advice changes on how to deal with it. So, rather than trying to contain it by contact tracing and isolating people, getting anyone with symptoms to get a test, I think it moves into paragraph 105, where I talk a bit more about the Public Health Wales advice, which is that if you have symptoms stay at home, unless you're too ill, then contact the NHS 111, and that broadly means that you'll then be given advice on whether to attend the health service or actually be given a test.

So, you know, this is in the last few days in the run-up to lockdown, it came quite quickly, actually.

Q. Thank you.

Can I then ask the same question from the perspective of what capacity there existed in Wales as at 13 March in respect of contact tracing. And obviously you talk about the local contact tracing availability but can we please just solidify your evidence about that as a resource in Wales as of 13 March 2020, please.

A. So as at 13 March we're still in a position where we were contact tracing from new confirmed cases. That was being undertaken by Public Health Wales. And I don't think it was on the 13th but I think within a day or two I did visit -- it is covered in my statement, forgive me, I can't remember the paragraph -- I visited the Public Health Wales centre and I met the chief executive and number of people and they talked me through what they could see happening and the staff who were doing the contact tracing.

The challenge is, I think I've covered this in the statement, that Public Health Wales and the system they had was fit for purpose for a localised outbreak. I then give the example of the Llwynhendy TB outbreak. You could contact trace a community outbreak that could have dozens, potentially, of people with contacts.

But as community transmission becomes more sustained, their resources to do that can't match the tests they're being asked to meet, so they're redeploying people. And because they don't have the capacity to do that, there's a challenge about whether that's the right thing to do. And in any event they're starting to say: this isn't a sustainable position.

So on the 13th we're not in that position. By the time we come to community testing ending, there's

a recognition that Public Health Wales can't carry on community testing and contact tracing and still doing the job that's required, and we're into sustained community transition -- transmission by then.

And that I think I cover in paragraphs 105 and 106 of my statement.

Q. Thank you's.

And can I ask you, you've obviously mentioned an earlier TB outbreak and learning from that. I think there was a specific recommendation arriving from that outbreak linked to contact tracing. Are you able to assist in terms of the learning from that earlier TB outbreak, if that had been responded to by reference to contact tracing?

A. I can't assist you with that specific point, and about whether Public Health Wales were able to expand their contact tracing abilities or not.

Q. Okay.

A. But a TB outbreak that was localised, or even a measles outbreak, are entirely different to the challenges that we faced with the Covid-19.

Q. Thank you.

Can we then, please, go and display your paragraph 109, please, at page 26.

You tell us that:

"On 21 March 2020, [you] issued a Written Statement ... to update on testing capacity in Wales. Public Health Wales at that time had capacity for over 800 tests per day. The ambition that [you] had was for 6,000 tests a day by the 1 April, 8,000 by 7 April and 9,000 by the end of April."

So I'm just going to pause there but if that can remain on the screen, please.

Can I then ask you, please, Mr Gething, when did the serious planning around upscaling the testing ability in Wales start, please?

A. So Public Health Wales were the lead body before the pandemic, and they had been doing the work on trying to increase testing capacity, and I know that in the witness statement provided by Public Health Wales and from Giri Shankar and Rob Howe, I think, they go through in some more detail the work they were doing.

So this is one of, I think one of the definite points of learning is, at the start of the pandemic Public Health Wales are operating and doing this work as if it's, if you like, an enhanced incident as opposed to a nationwide challenge. And I say that in the sense that they were trying to deal with the challenge, and they were giving us their best understanding of what they'd be able to do.

I think in the statement of Dr Shankar and Dr Howe, they go through about the different groups of people they were talking with, the different platforms they were trying to increase, and of course the significant chunk of this that was the 5,000 tests that (unclear) that agreement from Roche. So Public Health Wales tell us this is what we think we can do and we then, I say we as in the government, me, issue a statement saying this is what we think we'll be able to do. Because there are lots of questions about testing by this point.

So only some of this is really about the uses for testing at that point in time. It's really, even by then, an understanding that if you're going to have sustained community transmission and community testing is going to come back, you need a much bigger testing infrastructure, so this is about the scale-up that needs to take place.

Unfortunately, as took place, the scale-up didn't happen. Some of that is down to the Roche agreement that never was. And some of that is also -- and I think this is covered in other statements as I've mentioned before -- some of the alternative testing platforms that were ordered didn't actually come through in the timescale that had initially been expected. So we had to take a number of steps, and including, I think

there's a Military Assistance Team review that goes through this as well.

So I think the suggestion on the expansion was more optimistic than fired in hard reality about what it would definitely be able to do.

Now, some of that is because there were things outside of people's control and so it was that the Roche agreement wasn't nailed down and legally enforceable and those tests went elsewhere.

Q. Thank you. And I appreciate that her Ladyship and you have touched upon the Roche agreement, but can we just deal with what you've recorded at paragraph 109 and appreciating that we may be only able to take this evidence some distance. You tell us that you agreed the figures based on a recommendation by officials and Public Health Wales in March to increase testing capacity. The recommendation used figures from Public Health Wales which was in discussions with Roche Diagnostics Limited to procure test kits.

Just pausing there, were you party to any of those discussions with Roche Diagnostics?

A. No, it was Public Health Wales directly dealing with Roche.

Q. Thank you. And you go on to say:

"The political pressure to give numbers on how

quickly and by how much testing would increase was understandable, but there were a number of elements which we could not control and which could not be incorporated into a numerical target. The numbers stated were the best estimate of the available capacity if we were able to increase capacity in line with the work that Public Health Wales led. The objective was to increase available capacity and set out the timeline."

And you have already referenced Roche on a couple of occasions and so can you help us understand from your perspective at that time how you were accommodating the figures that you anticipated you'd be receiving as tests pursuant to a potential contract with Roche, please?

A. So the Roche tests would have been 5,000 tests a day. So that's over half of the increase in tests that we were expecting to be able to achieve.

Q. Thank you.

A. It takes up the biggest part of it, and when that doesn't happen, obviously, we're never going to get to the ambitions that have been set out. And, you know, there's plenty of lessons, and I'm really keen not to point fingers at people. It's what happened. And in normal times when you're having discussions about wanting to do something and you reach the depth that Public Health Wales say they did, you'd expect to be

able to rely on that. But once you say that in public, it takes on a different form. And I think there were plenty of people bruised by it, but we just had to get on and deal with where we were.

Q. Thank you.

A. But it was challenging.

Q. Can I then ask you, before March, when essentially it could be seen certainly from the January onwards that something was coming that needed tests and the PCR tests, did you have any direct discussions with Public Health Wales about the scaling up of the testing capacity within the Public Health Wales laboratories and what additionally that could harvest by way of available capacity?

A. So from the January, when there was an incident, it wasn't clear that coronavirus would arrive or arrive in the same way that it had done. But I think, collectively across the UK, because SARS and MERS hadn't been worldwide issues in the way they were in the southeast Asia, there was a view, and I think this is gone through in the evidence of multiple chief medical officers, not just Frank Atherton, but the view was that it was something to keep an eye on as opposed to to plan to have to expand testing in the way that we did.

Public Health Wales and their analysts do set out

that they were looking at how to increase testing capacity and how laboratory tests were developed that would allow you to understand if someone had Covid or not.

The challenge of what was being done by the NHS laboratory network was largely run by Public Health Wales. There was scale-up that took place, and I think, in later documents, it goes through the work that they were already doing. So as we go through the pandemic, and the need to increase the tests, Public Health Wales are telling us in the government with the Chief Medical Officer and directly in some meetings with myself and with (unclear) the First Minister, what they're doing, and what they think they'll be able to do. That's the basis of the announcement that I make.

We continue despite the Roche issues, to try to increase capacity and by the end of May we have significantly increased capacity across our own NHS Wales network, but the challenge is, in this period of time, that we weren't going to be able to go as fast as we had anticipated and it was announced in struggling.

Q. Can I ask you, Mr Gething, just to keep your voice up. I'm struggling slightly. Your voice tapers off at the end of answers so if you could perhaps keep your voice up, please. Thank you.

Can we then move along and I'm not going to deal with all of the chronology of the detail you set out in the witness statement, but can we look, please, at paragraph 115, please. You tell us that --

A. Yes.

Q. -- sorry, 115 on page 27. Thank you.

"Following Ministerial Advice ... [you] agreed the first National Covid-19 Test Plan. This was the start of the Test, Trace, Protect programme in Wales."

You tell us that:

"The National Covid-19 Test Plan was developed under the direction of the Chief Scientific Adviser for Health, Dr Rob Orford, and with the benefit of contributions from a range of stakeholders and experts."

You tell us that the plan proposed six workstreams which included Public Health Wales leading on increasing testing for Covid-19 infection through PCR testing with the priorities being to test patients, vulnerable groups and frontline staff.

So can I ask you then, please, you'll know that one of the issues that's particularly important to the Covid Bereaved Families for Justice Cymru is the availability of tests in respect of asymptomatic transmission, and I think you've been asked about this before, but can I ask you now to turn to your paragraph 175, please.

Thank you. So at page 49, please, paragraph 175.

A. Yes.

Q. Now, essentially, this is where you land about whether or not there could have been asymptomatic testing, I think, before it was introduced on 18 May of 2020. You say this:

"Looking back at this period, I do not think it would have been practicable to adopt a more precautionary approach and implement a programme of asymptomatic testing at the early stage of the pandemic. Our understanding about the value of asymptomatic testing was still developing and the advice I received at the time [to which you have obviously given the run-up before we get to this position] did not advise that testing should be required of those without symptoms. If I had chosen to do so despite the public health and scientific advice, then I would have consciously chosen to move resource away from identified and understood priorities. More so, I could have potentially increased harm if tests had not been available for identified high risk areas. Had the advice in fact have been to implement such a programme, the testing capacity was simply not available at the time to implement it and there is no value in adopting a policy which cannot be implemented."

And please Mr Gething, if you can allow me to explore the theme of asymptomatic testing and transmission but before doing so can I just be clear, we know that 18 May 2020, the policy changed to permit the testing, but can I be clear: is it your position that there was no point prior to 18 May where there would have been sufficient tests available in Wales to have tested those without symptoms?

A. Well, I think it depends which cohort of the population you're looking to test, and that's the point. So our understanding of asymptomatic testing progresses, as I set out in this paragraph. From a point where the advice is: only test people with symptoms to then being there could be a case to test asymptomatic people but actually you should still prioritise testing for these groups of people with symptoms and, in particular, vulnerable people, people coming to admission in a hospital, and we also have the challenges of testing on discharge because there was a real risk that discharge from the hospital to the care home environment would cease if we weren't able to test on discharge.

And what I'm trying to set up in this paragraph is that when our evidence changes, and we also then have an increase in capacity, so when we don't have the capacity, I know there are, somebody said we should have

been testing asymptomatically at a much earlier point, but at that point the advice and the evidence wasn't there to test asymptomatically.

If we had had that evidence, we would have had a very practical challenge of how to prioritise the tests. So even if we'd had that advice at a much earlier stage, we would still have had to prioritise about who we're testing and why. And it's as we go through into May that our testing capacity has started to significantly increase, both from the UK portals, that are starting to become available for tests being sent out, as well as the increase in NHS Wales testing capacity as well. So I'm trying in this paragraph to honestly reflect that journey of the state of knowledge at the time and even, looking back, what we would have done with the limited capacity we had that was starting to increase.

Q. Thank you.

And can I ask you then to give an idea -- we know that the Lighthouse laboratories in the United Kingdom, so the four that were operating from April of 2020, were starting their increase in scaling up of testing, so, looking at May 2020, are you able to give us an idea as to how many tests through the National Testing Programme and through the Lighthouse laboratories were being

provided to Wales in May 2020? Appreciating it's very early days of the Lighthouse laboratories.

A. No, I couldn't tell you offhand but I'm sure we could find the figures for the practical increase in testing availability, because I think in later documents there are documents that refer to the amount of tests. I think I saw a document that talked about 2,100 tests being available from NHS Wales at the start of May, and that then increases in the next couple of weeks. But we do -- by then, we're starting to get access to Lighthouse labs as well. And it's through these early few weeks in May that the home testing routes are opened, and so tests can be sent out and then returned to Lighthouse labs.

So, forgive me if I'm wrong, I think at the start of May we had 2,100 tests available each day, and that increases in the next few weeks, so I think by the third week of May we're into several thousand more. But if it's an important point of accuracy I need to (unclear), then I'm sure we can find the correct figures.

Q. No, thank you, I'm sure all of that data is available for us when we do the interrogation work, Mr Gething.

So, broadly speaking, we've captured your view about testing availability, but I want to then come back on the asymptomatic point, please, to understand the advice

and the understood position in May of 2020, because it seems there was dual considerations. You've already dealt with capacity, but can I ask you then, in terms of before May 2020, from your perspective, had anyone provided advice to you in terms to the effect of this is a serious issue of asymptomatic transmission that needs to be addressed because it is particular issue for healthcare workers?

A. Not in those bald terms. So -- and there's -- I think the points that are made by both Frank Atherton and Rob Orford about the difference between asymptomatic infection and asymptomatic transmission, and there was a Diamond Princess incident, the cruise ship where a number of people tested positive but didn't have symptoms. So this wasn't a position where people denied the possibility that anyone could have Covid without the symptoms. It was more about are you able to infect other people if you don't have symptoms, and the changing state of knowledge at the time.

And as it became, it's not just possible but more likely that some people without symptoms can transmit the virus, it's still, then: what do you do with the resource that you have? But the advice was still very much, up to the end of April, towards the end of April, that the case had not been made for us, in terms of the

advice that we received as ministers to make decisions, from our public health advisers or indeed our scientific advisers, that there was a compelling case to test asymptomatic individuals.

By the end of April, though, at the end of April, we are coming to a very uncomfortable couple of weeks and changes in policy, and announcements made in England. And this is particularly different because I know that our Chief Medical Officer was unhappy about the way that announcements were made without there being a discussion between chief medical officers about why the position had changed. And I've covered this in both my Module 2B evidence and indeed in this statement as well. But the state of knowledge and the advice provided to ministers changes over this two to three-week period fairly significantly.

Q. Thank you. And is that to address, really, the fact that the testing for asymptomatic healthcare workers essentially came in at a later date to that introduced in the United Kingdom?

A. I'm trying to understand the question you're asking.

Q. So the question is, I think you've just indicated there's concerns about the advice and sharing advice with the Chief Medical Officer. And what I want to ask you is: is that answer you've just given, that had there

been clarity about what the United Kingdom was doing there might have been a similar response and policy implemented in Wales rather than --

LADY HALLETT: You mean England?

MS CARTWRIGHT: In England, sorry -- no, in Wales -- in Wales would have come in line with the United Kingdom Government, rather than the later date on 18 May?

A. Yeah, we were finding out things as they were being announced, and the frustration is that chief medical officers are talking, health ministers are having a weekly call, and that actually the evidential base isn't being shared in the way it's then being used to justify announcements.

That's one of the challenges of having to deal with announcements on the hop. And then from a point of -- the criticism that is then made is "This is happening across England" rather than "This a change in policy that will take time to implement". And actually, I think we could all have moved at the same speed if there had been rather more informed and trusting discussions, which -- like I said, it's not just in my evidence; it's in the evidence of a range of others, including our own Chief Medical Officer at the time.

Q. Thank you.

And then can I ask you, with what appears to be,

from that answer, a degree of frustration about what was happening at the time, essentially you finding out at the time of announcements being made by the United Kingdom Government and, to use your phrase, finding out about decisions "on the hop", did you challenge and give feedback about that, and that being unacceptable by way of a partner who equally needed to be sighted on matters before they were put in the public domain?

A. Yes. And I wasn't the only one. You know, health ministers talked about it, and I wasn't the only health minister who said this isn't healthy and shouldn't be done. And I think in the notes you've got a meeting that took place on 30 April where Frank Atherton is unusually robust in expressing his disappointment at a meeting with other CMOs about what's been happening and announcements that are being made.

There's a human part to this, you know, about the frustration of "I shouldn't find out this way", but actually it matters when you're still trying to take the public with you and about trying to trust you on really significant choices you're still having to make. So ...

Q. Thank you.

A. It's a point of learning that I've gone through in more than one part of my evidence in this module and others about governments, plural, regardless of political

differences, needing to trust each other and share information on a much more timely basis.

Q. Thank you.

Now, you've referenced steps that Mr Atherton took, but can we just be clear who you took that issue up with when you were raising the concern. Is there an identifiable individual where you were saying, "This is simply not acceptable" --

A. Oh, I'm sure that I raised it in one of our four nations health ministers calls. And I am confident that I wasn't the only health minister that raised it (unclear) was also pretty robust when announcements were made by the UK Government for England.

Q. Thank you. Sorry I interrupted the end of that answer and it drifted off, but can I ask you then, when you were raising that concern, was it also, through the context that you've just said, that it was as important then that the public had confidence in the decision making of the respective governments?

A. Yes, it was a point that I regularly raised in a range of fora, not just on this issue, but on other times where UK Government choices were made for England, and they were -- you know, I knew to ask when they were made. Because if you were doing an interview, as I regularly did -- I did media rounds late at night and

early morning -- and then you are asked, "Why has this decision been made and why are you doing it?", I think it's a terrible answer to say, "Because I didn't know and no one talked to me."

That is no way to maintain public trust and confidence at a really crucial time.

So it isn't really about the politics of it, it is actually about the job is too serious at this point in time, and we can have all of our disagreements, but on this we should at least be able to share information to make sure we're not put in the invidious position of looking like you're having -- you know, you're taking an opportunity to score political points rather than actually just saying to the public: health ministers don't talk to each other and don't know what's going on.

That's a really poor position to get into and I think the watching and listening public would rightly be concerned about it.

Q. Thank you. And did the dialogue between health ministers improve throughout the pandemic?

A. Well, health ministers regularly talked to each other even when we didn't agree with each other. So even in an instance like this where, you know, I think, quite rightly feeling bruised and annoyed -- and I'm being polite about what's happened -- you still need to turn

up and talk to your colleagues across other nations, because the alternative of walking away is worse, because then you really don't have a way to try and share things and try to get things right.

So you can't express all your frustration in public at the time, because that isn't always very productive. And that's hard because politicians like to express their frustrations in public, and I recognise I'm guilty of that on occasion.

Q. Thank you.

Now, Mr Gething, I'm just going to complete the point on asymptomatic point and knowledge and advice, please. You've obviously already referenced in giving your answer to the Princess cruise which was in February 2020, which I think had identified a high volume of transmission and asymptomatically, I think it got near to the figure of 50 per cent. So is it likely, then, from what you have said that you would have had some knowledge about that in February 2020, with you volunteering that information?

A. Not in February 2020, because that isn't when it was reported or brought up to me, but as we came through April, certainly I was aware there had been an incident on a cruise ship that had been reported to me, and then I started to see the studies that England had relied on

to shift their position on testing as well. So I certainly wasn't aware about the Diamond Princess in February 2020 and I don't think the paper had been written at that time either.

Q. Okay, thank you. Well, then can we look at the ministerial advice from 8 March, please which, is INQ000235863. That's INQ000265863. Thank you.

This is ministerial advice a year later, 8 March 2021.

A. Yes.

Q. If we can turn to page 2, please, to just see the identified volume. I think it identifies a third cases are asymptomatic. And we can see reference to May of 2020 again:

"... the scope and scale of contact tracing should include the rapid testing of all suspected cases of Covid-19 ... Contacts of positive Covid-19 cases have only been advised -- to date -- to take tests when they become symptomatic, unless they are part of a separate scheme under our testing strategy."

Can I then -- take that down, please, but ask you then -- and this is information that sort of builds on what you said in Module 2B, I think Mr Drakeford, we're aware of spoke, to the Senedd on 24 March 2020, and gave the information to the Senedd that while you're

asymptomatic you could be passing on the virus on to somebody who is much more vulnerable, and that fed into the decision to stay at home.

Were you aware of that position as of about 24 March 2020?

A. It was a possibility yes. This is definitely 24 March 2020, not '21?

Q. We're 2020 now.

A. Yeah, so we're asking people to stay at home. You know, that's when we're starting to go into lockdown. That's all the choices that are being made at that point about why does everyone have to stay at home.

Q. Thank you. Can I then take you, please, to the ministerial advice from the 30 April 2020, please, which is INQ000336477. Thank you.

So ministerial advice now 30 April 2020. And if we can turn, in that document, please, to the second page. I think it identifies that 25,000 extra tests would be needed to test any asymptomatic care home residents in Wales and that choices need to be made about how to deploy testing capacity which inevitably means trade-off.

So certainly by the end of April, would you agree that there seems to be knowledge developing around asymptomatic testing needed in care homes?

A. Yes, and this advice sets that out on the next page, it isn't on the screen. It goes through --
Q. Thank you. Can we turn to the next page. Thank you.
A. Yes, so it goes through more of those numbers and support of the sector and then looks at the bottom of this about what's happening in England. And the announcement that the department make in England, I think I saw in a later note that it will take four weeks to get through the testing that they announced in England.
Q. Yes.
A. So we then had to think about what are we going to do, what is our access to the different routes that are available? And so there's the point about maintaining confidence as well as what does our advice tell us about what is the right thing to do, and this is giving a summary of those different factors with the recommendations at the end of the advice.
Q. Thank you. That can be removed from the screen, please.
Mr Gething, we appreciate also that an opening statement was made by the Welsh Government that essentially lands that before, essentially, the decision was made it probably wouldn't have been possible to have made a different approach on asymptomatic testing sooner, but can I be clear from your perspective,

looking at that advice from April of 2020, and in the knowledge that there's a further 18 or so days before it was introduced in Wales, would you accept that there was a potential for at least two weeks earlier, for testing, asymptomatic testing to have been introduced in Wales?
A. Well, there's always potential, but that advice in the next page that wasn't on the screen goes through the choices to try to make. So it does say at that point, if there's a single case in a care home, to treat it as an outbreak and test everyone in the care home. Staff and residents. It then goes through the challenges of surveillance testing, where people can request tests by getting access to the -- it's called the home delivery portal but, of course, a care home isn't a home in the traditional sense for staff, certainly.
So we're going through, then, what we're trying to do about making testing more widely available in line with our understanding of asymptomatic transmission and the risks at the time.
It's always possible, when you look back in hindsight, that you could have introduced the policy earlier. And given the state of knowledge we have now, then as soon as we have the capacity available, then yes, it would have made -- there would have been a proper case for providing testing on a different

basis, that we eventually moved to from the period of the end of April to, I think, 16 to 19 May when the policy position has changed. And that's pretty uncomfortable because you're trying to give assurance to people, and actually, you need to be able to move, as the evidence base changes around, and this is exactly one of those instances, where, as the evidence base changes you have to change your position because otherwise you're doing the wrong thing in the light of the evidence that's around you.
Q. Thank you. Can we then, in the context of that question around an ability -- and I know you've identified hindsight -- has to be considered here. But can we look, please, at INQ000530780.
Just in terms of capacity as at the end of April, please. Thank you. I think if we go -- thank you -- we can see there the capacity that existed at the time but also availability, and I think it's right, isn't it, that essentially during this period of time there was greater capacity in Wales than was being utilised. So there would have been available capacity.
A. Yeah, and in fact I think I've got emails that show -- I don't know if it is this set of figures or a different one, but I ask officials: what is happening? Why do we have capacity that's going unused? When, actually, we

know we've got a range of policy challenges we're talking about and we're not making use of the capacity we have. Why on earth is that? I don't have the number of the document but I know it's in the pack.
So it isn't as if there's a -- there's either a complacent or, you know, sort of lackadaisical view from me as a minister, I am both asking questions about what is happening with our ability to scale up our testing, and also, why we're not making more significant use of the capacity we have, and that is set out in the documents from the time as opposed to a matter of hindsight, about why are we not using more of these tests that we have available to us?
Q. Thank you. I think can we just display, to do with the point of underusing capacity, please, INQ000136804. Thank you.
And can we move within this ministerial advice of 5 August 2020, please, to internal page 7.
I think, again, we can see essentially the summary there that indicates availability and underuse of the tests that did exist in Wales, that continued until the August of 2020. So is this a further illustration of, even following on from May onwards, that Wales did have more tests than were being utilised by individuals living in Wales?

A. No, the situation is quite different by August. So in April and May we're coming towards the end of lockdown, prevalence is still relatively high compared to August. And we then think about what then happens when you look to start easing as well as trying to protect the care home environment?

By August the situation is really different. Covid levels are really low across Wales, they're sort of one or two per hundred thousand. So at this point, part of the reason why people aren't getting tested is more than one: it's both because Covid rates are low, but it's also because people are, at this point, looking forward to more easements as we are going through what was mercifully a good summer, weather-wise. So I wouldn't have expected there to have been the highest use of tests at this point in time. The real issue, though, is making proper use of the capacity we have and that becomes more and more of an issue as we go into September and October as rates start to rise.

Q. Okay. And then can I ask you in terms of the final bullet point before paragraph 15, because obviously we see now you've got the access to the Lighthouse laboratory test, you say this -- sorry, the document says this:

"In the event we choose to route all asymptomatic

testing of care home staff through the UK portal and the Lighthouse labs and issues arose relating to the capacity of the Lighthouse labs, we would have the contingency of being able to ask the LHBs to conduct testing through the NHS Wales labs."

Can you just make clear what's being discussed there about choices, to route asymptomatic testing through the Lighthouse labs as opposed to the local health boards, please?

A. So if you have regular asymptomatic testing it's a predictable amount going on every week, because I think at this point we're testing care homes every -- I think we moved from weekly to fortnightly, but there was a slightly higher rate in North Wales so they stayed on a weekly rate. We had got a predictable amount of tests we were using through the Lighthouse labs, and as I say, prevalence is low but this is now providing some reassurance and rooting out cases that come through without symptoms.

If there is a problem with Lighthouse labs in the earlier part of the advice, coming on the two bullet points above, talks about how Lighthouse labs weren't operating at their usual daily capacity. So if there's a problem with Lighthouse labs and you know you need to do something, for example, on targeted testing on a care

home when there might be an outbreak, you can switch away from the Lighthouse labs to the extra capacity we've already created in NHS Wales labs at that point, NHBs, our local health boards.

So if health boards were concerned about an issue within a local population or a local care home, they could route those tests through the NHS Wales labs if there were a problem at Lighthouse labs, efficiency and speed at that point in time.

Q. Thank you.

A. It's flexing our resource.

Q. Thank you. And that can be taken down now, please, and I think -- can I ask you, then, about alongside the, obviously, increase of testing with the access to your share of tests from the Lighthouse laboratories, can I ask you a question about the contact tracing that then followed the increase in testing, please and can we move to your paragraph 147, please, at page 39.

That's paragraph 147 at page 39. Thank you.

Now you, following on from the ministerial advice of 18 May, you indicate that the advice:

"... was submitted to me advising on an all-Wales digital contact tracing and case management platform. A rapid review of existing relevant digital infrastructure in the UK and elsewhere had concluded

that a new all-Wales platform was needed to support effective and consistent delivery of the Test, Trace, Protect approach at the scale which would be required."

You say this:

"My understanding of the risks and benefits of an all-Wales platform was based on the advice from officials which explained that the platform was necessary as the Public Health Wales' 'Tarian' system, which had been used to trace contacts earlier in the pandemic, was not designed to undertake the scale of tracing envisaged and the review had shown that it could not be re-engineered to cope with the task at hand."

Over the page, please:

"I understood that the new platform would initially use the UK Contact Tracing and Advice Service ... website, but instead of the limited, selective, data collected by the UK Contact Tracing and Advice Service in England, a full data feed would be taken for users in Wales to support the more detailed contact tracing approach we planned to implement. The advice sought my agreement to the deployment of a new all-Wales digital customer relations and case management platform to support overall arrangements for Covid-19 contact tracing across Wales. I agreed to this recommendation. Again, I had discussed the development of and rationale

for this approach with officials before the formal advice was provided."

Can you assist us, then, with the timing of this? And again, Mr Gething, whether steps to have that contact tracing service set up in Wales could have been done sooner, please.

A. This goes back to some of your earlier questions, counsel, where you were asking about the contact tracing system and the end of community testing. So Tarian, the Public Health Wales system, is fine for a community outbreak; it's not fine for a national contact tracing effort with the much greater volumes that are required. So we had to get a new system. And there had been discussions. I remember several meetings with officials looking at the options to do that. There was the prospect of using the same system as the UK Government were using for England and there were a couple of other potential options as well and we eventually came down to a system that -- I was advised, and I took and accepted the advice after discussions, that we would have a greater ability with more utility if we had a slightly different system to the one that England had.

Now, the reason why our contact tracing system needed to be dealt with was (a) because we knew the Public Health Wales system couldn't cope, we knew that

contact tracing coming out of lockdown would be really important to understand where new infections were taking place and the chains of transmission, and that meant you had to have a system that could cope with that, both the digital aspect, if you like, I think this is referred to as the customer relations and case management platform, but you also then need the people to do it. And as we were going through, actually having contact tracing available from early June is really important, because of the stage we're at in further easements and more people see each other, there's more potential for the virus to take off again as more contact is made, and in particular, for the reopening of schools, because schools were due to open for a check-in, and having a symptom that was working was important for the reopening of schools.

So there's a range of different areas, and I actually think that going from not having a national contact tracing platform to having not just a platform but a service that was staffed and ready to go in a couple of months was a really significant achievement.

Q. Thank you.

A. You could always look and say: could we and should we have done it sooner? But I still think that this is a significant achievement for all the people who were

involved in it, including the people who transferred and moved around local authorities and others to provide the actual service.

Q. Thank you. And sorry I --

A. And that's where we got to.

Q. Thank you. And with looking at this being explored on 18 May, are you able to help us as to when in fact the platform was operational, please?

A. I think the platform was fully operational for at least the week of 8 June. We opened the service on 1 June, so contact tracing started. But I think we did, for a week, make use of the service from the UK Government front-end portal. But by then all of the data was then coming through our own system. So -- yes, that's the period of time.

And, you know, 18 May is when the advice comes up, but there are weeks of discussion with -- discussions with officials about this, so it isn't that this suddenly appears as a new thing in the middle of May.

Q. Thank you.

Can we look at that ministerial advice, please.

Which is INQ000144886, thank you.

And if we just move through the document, it was one of the documents provided -- thank you.

Obviously this was looking at the range of options

for the platform, and then -- thank you.

Having refreshed your memory, admittedly at speed, Mr Gething, one of the things I want to ask, and appreciating where you've landed with my questions so far is you were able to achieve it as quickly as you did, that you think was a commendable thing, but I just want to ask this question, please: obviously it looks like steps were being taken as a rapid piece of work in late April and early May to scope the main requirements for this contact tracing system and that one of the key factors in assessing various platform options against Welsh requirements was being able to deploy it in the extremely challenging timescale of three weeks, noting that this requirement ruled out a number of potential platforms.

Do you have any view as to there was an ability, first of all, to have this available sooner, and, if there was, to what extent that had an impact on infections and deaths at that time, please?

A. So I don't think this does affect infections and deaths in the first phase of the pandemic. That's because, when the lockdown choice is made, it squashes the curve of infections really significantly, so it's actually the behaviour response of the public that really takes the top off the exponential curve. And that was more so

than, to be fair, was expecting. The level of public compliance and behaviour change made an even bigger difference than our behavioural science and public health advisers thought it would do.

By this point in May, we are thinking about the next stage of easements to gradually come out of lockdown. And so the work that starts from, you know, the very, very challenging circumstances at the end of March and early April, where we're then looking at needing to have a contact tracing service and system with a digital capability behind it, part of it is wanting something that is bespoke to do with our circumstances but is from a stable platform, it's got a record of being used. So that then means that you're not looking at an entirely novel system because you'd have to test that in a way that you didn't have time to.

So the speed at which this has to be done does govern some of the choices that you have practically. But -- because you need it to work. You know, you can't go through a development phase and say "We'll have six months of trialling it." In normal government terms, doing something within a year on a national basis is rapid. We're doing this in a matter of weeks. And it's that urgency that is very much there in the work of officials and the way in which the service was created.

So, not having an effective service would have made a difference when we opened up through the summer and go into the autumn, and if we had got this wrong, then that definitely would have made a difference on infections and mortality, I'm afraid.

Q. Thank you. And Mr Gething, having scoped up and scaled up this contact tracing resource, does that still exist in Wales?

A. No, there is no national contact tracing service of this scale because we're in a different phase.

Q. No, sorry. My question was unclear. I do apologise.

Is the platform still available, though, for scaling up if it needs to be used in a future pandemic?

A. I think the learning that's there from what the system is, yes, that learning is there. And it all depends about your ability to make choices. Because if you're having a new pandemic, and say it was, I don't know, god forbid, this winter, well, all the learning we've had, you'd probably make choices much earlier about what to do, including when and how to re-scale-up contact tracing and how to get the testing infrastructure right as well.

So if there were another pandemic, I would expect that it could happen sooner, because I think you'd make choices earlier to get contact tracing up and running.

So in a roundabout way, I think the learning is there, and I think the capability would be there, but I can't tell you what the digital platform would be available likely in another 10 to 20 years' time. You're going to need to constantly look again at what is available for this purpose, if we ever had to do it again.

Q. Thank you.

That can be removed from the screen, thank you.

Can I then ask you a question about the contact tracing app that then was available within Wales, and it's a question, really, whether you can assist by way of information we have about the uptake of the contact tracing app, and whether, in your role as the relevant minister, you can give any reflections or insight into what looks to be relatively low uptake in Wales.

Now there may be a better version than the INQ I'm about to give but the INQ where -- the graph that I want to take you to, that I'm aware of at the moment, is INQ000574818, at page 2, but if a better version is now available, please display that document. I'm afraid I don't have the INQ. But if not the default position would be, please, INQ000574 -- ah, thank you. And can we expand, please, the map B.

And I hope Mr Gething, that you can see that clearly

enough.

Now, this graph is to reflect the uptake of the contact tracing app when it was available from 24 September 2020 onwards, but we can see that almost universally across Wales, the uptake by way of usage and downloading of that app, save for the small pockets in the darker green and yellow, is almost at the 16-20% uptake for what was intended to be an app that essentially had lots of abilities, including to notify of tests but also the need to isolate, particularly when the isolation became enforceable both in the United Kingdom -- sorry, in England, but also Wales similarly made the isolation also enforceable.

Are you able to help us as to any reflections or evidence you have that might assist with why there was such a low uptake in Wales?

A. It's a proximity app. I think calling it a contact tracing app is perhaps to overstate what it is, but it's the NHSX app that we went in with on an England and Wales basis as a useful addition but not a substitute to the contact tracing system we'd created.

As for the lower take-up, I can't give you mathematical or scientific explanation, but I do think it is worthwhile reflecting that trust in the person promoting the application matters. And so, you know, do

you think that this will help you? Do you trust the people delivering it? And also, whether or not this was seen as necessary, in the sense of -- you know, by this point we'd already been running through contact tracing come September, we were publishing our figures, there were people being called, as well as the digital interface, and we had a pretty good record of both getting to large numbers of people and their contacts but also getting to them pretty quickly as well.

So -- but I think beyond that I'd be getting into real supposition that I don't think would assist the Inquiry.

Q. No, and, Mr Gething, I'm not asking you to do that. But can I, though, just expand about the Covid-19 app, which you're right to confirm it didn't just have a contact tracing role, in terms of it also had other functionality which included, if you were told via the app that you needed to isolate, it was essentially linked to the regulations that meant it was enforceable if you didn't isolate, and it also had the countdown counter within the app that then told you when you were able then to essentially stop isolating.

And was there any work then being done, particularly when Wales made the decision also -- so England and Wales had determined that the isolation requirement was

enforceable with essentially criminal or penalty sanction. Northern Ireland and Scotland did not do so. Was there any thought given around how that was being communicated, linked to the fact that Wales had made a decision to also make isolation enforceable if the individual did not do so?

A. Well, we ran a Keep Wales Safe campaign, where we tried to have simple messaging about what we'd encourage people to do to keep themselves and loved ones and people that they would probably never meet as safe as possible. I think the risk always is that if you add an extra layer of messaging that (unclear) whether you're taking away from your main -- what you're asking people to do.

Certainly in press conferences and in the Senedd we talked about the fact that there was an app. I downloaded it and used it myself. We certainly talked about the fact that the strong guidance moved into being the law and enforceable. So we didn't not talk about it, but I couldn't honestly tell you about why the take-up differed so visibly between Wales and England for take-up and usage of the app itself.

Q. Thank you. Can I then ask a question, please, around the legal enforcement, please. And can we move, please, to your paragraph 286 within your witness statement.

It's paragraph 286 at page 80, please.

Thank you. I think you're dealing there with the fact that self-isolation became a legal requirement. And can I ask you a question linked to, please, whether you can assist: given the difficulties some from the black, Asian, minority ethnic community faced with isolating, do you accept or have any views as to whether the measure of making isolation enforceable may have put those individuals in a precarious position?

A. I think the challenge was the financial support that came with it, because, you know, I know I've covered this in my Module 2B meeting, it definitely was part of discussions we had both in the Senedd and indeed in health ministers meeting, that -- and it's all linked to Statutory Sick Pay as well. If you're asking people to isolate, you're asking them to do something that both benefits them and people around them as well, and their wider community.

Asking someone to do the right thing when you're potentially asking them to choose between whether to pay their bills or feed their family or do the right thing for other people is an invidious position to put people in. So people who have less income find self-isolating more challenging from a financial point of view, as well as people in their own individual circumstance, if

they're already isolated and going out to work as part of them not being isolated, in a pretty precarious position.

So the duty also came about wanting to have a new settlement after the fire break ended in Wales, because that's the timing we're talking about here, about self-isolating within guidance to the law, and also we'd finally had to agree that there be funding a payment that was currently at £500, we eventually moved that to £750 in Wales, to help people to self-isolate because otherwise you really are placing people in the invidious position that I mentioned.

I think the position for black and brown people is that, broadly, we're more likely to be in lower income occupations. So, you know, black and Asian minorities are much more likely to be covered in this group in a population as a whole, but you need to make a choice about whether this is the right thing to do. And in many ways it's about the messaging: the messaging that this is so serious that we're changing the law.

And as I said, at this point this is a -- this is a deeply uncomfortable time, because we're going through the fire break and the politics has really taken up. It's much more contested. There's open criticism by the UK Government of the measures we're taking in Wales,

where there's a really different approach, sort of "This lockdown in Wales is going to destroy jobs and it's not necessary", and dealing with all of that at the time is a really big challenge. And then we get to the firebreak ending and rates took back off fairly quickly. So this is very, very uncomfortable.

I think if we hadn't provided a payment to help manage self-isolation, then I genuinely think the situation would likely have been worse, not better, with people actually complying with the requirement.

Q. Thank you. Can we move to paragraph 200 briefly.

There's this topic and then any views on recommendations, and then that will complete my questioning. Paragraph 200, please, at page 57, essentially picking up on two of the themes we've just looked at together, so paragraph 200, page 57.

Now, starting with paragraph 200, you've already identified that Wales introduced an isolation payment of £500 to cover lost income, that came on in the -- just after September, I think it was October, the date in 2020 that Wales' scheme was available. So, first of all, can you assist us, having identified the importance of a payment to support isolation, why it took so long for that to be available in Wales, first of all?

A. Because you need to make sure that payment can actually

be processed and delivered to people. So again, it's the time that it takes, and I really would wish that our systems were faster but you're doing lots of novel things to try to get this money out and available.

Q. Thank you. And I appreciate, also, that Wales was the only -- that was unique from England, in particular, that you increased the payment to 750 for a short period of time also, and can I ask, in terms of that decision making, were you involved in the decision to increase the figures?

A. Yeah, I was copied in on the advice, and of course I was still in the cabinet at the time. So in that sense, yes, but I wasn't the official decision-taking minister. I think it was either the First Minister or the Minister for Housing and Local Government.

Q. Thank you. Can we then continue with this paragraph, please, because the question I want to ask you about, if you look over the page, please, you essentially are detailing in paragraph 200 discussions and interactions you had with the chief constable of Dyfed Powys Police Force about the disproportionate use of fixed penalty notices against the black, Asian and minority ethnic community. And can I ask you, then, what action did you or other members of the Welsh Government take in response to these issues?

A. So it was a discussion that went through the police force, so that was chaired by the Deputy Minister for Social Partnership and the First Minister attended as well. I think I attended a handful of those meetings. But, you know, 7% of people in Dyfed Powys are not from a black or Asian background so the chief constable had recognised that what looked, on the face of it, a disproportionate use of fixed penalties against black and Asian-origin people.

So that recognition that this is a problem, I think it's positive that the police recognised it, but it's then what they do with their officers, because I think on these issues, they are often unconscious. And I know that that's uncomfortable for people to still talk about unconscious bias, but it's real, and I think this is a very good example of that. I don't think that the Dyfed Powys Police Force has got lots of overtly racist officers, but this just shows that when you apply a blanket measure and you apply it to a whole population it can have a disproportionate impact, and that isn't explained by differing levels of criminality; it isn't explained by different levels of income, it's about how the engagement and education approach moves to enforcement.

And that, I think, is the lesson here.

Q. Thank you.

A. And it shouldn't be a surprise, either.

Q. Mr Gething, can I move then finally from my questions before we go to Core Participants to your recommendations and lesson learning section please, but it's your paragraph 382 I want to take you to, please, on page 102.

A. Yes.

Q. I think you detail there, that:

"By advising people to self-isolate without clear advice on financial support we were essentially forcing them [to] make, for what would be for many an impossible choice between their own, their family, and their community's health and financial survival. It is important that we recognise the difficult position we put people in and address Statutory Sick Pay much earlier in the event of a future pandemic."

Can I ask you, would you agree that the context of, perhaps, the delay to give or the failure to give clear advice on financial support to people in advising them to self-isolate was something that would or should have been obvious in the planning stages and acted upon accordingly?

A. It's obvious now, but, we had not had a nationwide challenge like this. At my most generous, I could

understand why initially people in the Treasury and others didn't see the importance of this. But it was a lively discussion through health ministers' meeting, and I wasn't the only one who was making the case but I certainly made the case for changes to Statutory Sick Pay, and, you know, it was essentially a Treasury choice not to change that. This is not devolved. I got a very unsatisfactory letter from Thérèse Coffey that I cover in my evidence, but if you ask people to make this choice, don't be surprised they choose to keep on putting a roof over their family's head.

And, you know, if you're not going to equip them financially, to make the right choice for the community and the country, then, you know, this is what you can expect. I don't think you can say that the people who are making this choice are selfish, or are deliberately making a choice that is wrong for the country and they don't care about that. They're making a choice that is rational in the circumstances that they live in, and I think this is definitely a lesson, and I think I've put this in some previous evidence as well, my module 2B statement, that I think we could and should have a system where, in a pandemic, you rapidly change the rules to provide financial measures to support people in self-isolation, who have got to meet the reality of

their financial means and obligations as well.

Q. Then finally for my question on -- continuing on the theme. We're not hearing live evidence from Dr Orford, but we have evidence from Dr Orford that identifies and says that:

"Unless social inequalities are targeted by governments, then underlying structural and societal factors related to health inequality will influence the accumulation of deaths, hospitalisations and cases in the next pandemic and the resulting policy response, particularly non-medical will lead to other inequities."

Are you able to provide any reflections on how those issues can be addressed to prepare for future pandemics, please?

A. Well, that's a much wider question because, you know, he's absolutely right, you know, Covid was not a great leveller. It disproportionately impacted our most vulnerable communities. It disproportionately impacted our least financially well-off communities. If you look at a map of socioeconomic inequality and health inequalities, the two things map neatly on top of each other. If you don't address those socioeconomic and health inequalities, then another pandemic will have a similar disproportionate impact.

There's all the things about informal childcare, the

different (unclear) communities resources strength, the (unclear) in terms of spreading the transmission of it but it's also about the fact that if you've got four comorbidities and you're 50, and a counterpart in different community is in a different place, over a whole population, the person with the four comorbidities at 50 is much more likely to come to harm. It's not a secret.

But that, though, is a really big challenge that requires sustained policy choices to be made about better paid jobs in different parts of the country, access to good quality food and nutrition, exercise, diet, smoking, alcohol, all those things, and they're not one thing that this Inquiry can deal with. They're a basket of measures that the country needs to be serious about, so I say the country, across the UK, if we're going to be in a different position if a future pandemic were to strike. But I think it matters regardless when there's a pandemic or not.

MS CARTWRIGHT: Mr Gething, thank you for answering my questions.

My Lady.

LADY HALLETT: Thank you, I think we'll carry on and finish, Mr Gething.

Ms Parsons.

Questions from MS PARSONS

MS PARSONS: Thank you. Thank you, my Lady.

Mr Gething, good afternoon. I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. My Lady, I can't actually see Mr Gething.

LADY HALLETT: Mr Gething, can you hear Ms Parsons?

A. I can. I can see her and hear her.

LADY HALLETT: Right. Thank you.

MS PARSONS: I want to ask you first, Mr Gething, about delays in the introduction of asymptomatic testing for healthcare workers in Wales.

Your statement refers to ministerial advice received on 20 November 2020, which advised on policy proposals for testing of healthcare workers and hospital staff. For your reference, that's paragraph 208 of your witness statement. That ministerial advice includes the following statement. I'll read it out:

"We need to build into the consideration a risk assessment approach, and balance the benefits of an asymptomatic testing programme as part of a nosocomial plan with the potential to severely impact operational services which could result in services being closed down where staff receive positive tests."

Now, this advice isn't until 20 November 2020, as

I said. The policy for healthcare workers wasn't introduced until 14 December 2020, and as we'll come to, many healthcare workers were not testing until March 2021. The question is this, Mr Gething: to what extent were these delays driven by concerns that positive tests would mean a depleted healthcare workforce?

A. Well, that certainly wasn't a consideration for me in the sense of not wanting to test because of the impact on the workforce. And we covered this a bit in Module 2B, and I know it's in the evidence of Phil Kloer as well, and I think I covered at the time that I was pretty frustrated at the lack of pace in the use of the tests. You know, once you've got lots of lateral flow tests available in particular, this is about protecting healthcare workers themselves as well as protecting their colleagues and, of course, the public.

So when I made the choice, I made the choice to say that this should be rolled out and introduced in the health service. I didn't make the choice to say, "Let's not do this" because otherwise it might affect areas of operation if staff have to take leave and isolate, that's a necessary consequence of where were at the time.

Q. I appreciate you say that's why you made the decision

then, but I'm asking about the delay. To what extent was the delay driven by concerns that there would be deleted healthcare workforce?

A. Well, I think you'd need to ask people who didn't implement it at the time and the pace that I expected it to be. And as I say, I think -- to be fair, I think Phil Kloer in his evidence was pretty upfront about it, about the reasons why they went at the pace they did and the areas they chose to roll it out.

If you're going to implement a nationwide service, I wouldn't expect it all to be delivered on the next day, because you've got to get your systems up and running, make sure who's getting it, where and how. So having a phased rollout through areas is fine, but for it to take that long, isn't fine. But as you know, I'm -- I think it's to everyone's benefit that I don't actually run health boards and make clinical decisions but when I make a ministerial choice, I expect the system to deliver on that choice. And equally, you know, if it's not happening, then I can't do anything about it if I don't know, and I don't think Welsh Government officials were really properly sighted on it either. It came up much later.

Q. Well, I was going to ask you about that, Mr Gething. Was the Welsh Government aware that it had taken so long

to implement its policy? And, of course, you'll be aware that the delay happened over a critical period for Wales. Nosocomial infections over that period were incredibly high and when I say "over that period", I mean November 2020 to March 2021, when your policy was supposed to be being rolled out. High rates of nosocomial infection and, of course, winter.

A. Well, that was the whole point about introducing the policy, to make sure that you don't compromise care by having staff who are infectious in the workplace. And I'm confident that I made this clear in my previous evidence in -- in previous modules, that I was unhappy to subsequently discover that this had taken quite so long to roll out, because that was not the intention behind the policy choice and it's an area that I do think there should be some learning on about if you're going to do this, you need to deal with it. Because if you don't, there are risks that come for everyone. And it was a really difficult time because we had the alpha variant, we had -- were into Christmas, the significant take-off in rates, the significant increase in mortality and it's part of the reason why we went into -- you know, all of those things led into the lockdown that took place before Christmas that we've covered at some length in previous evidence.

Q. Mr Gething, I want to ask you about delays more widely in your testing policies, please. I'm going to give you some examples. It's by no means an exhaustive list, but we know that there was a delay in routine testing for patients being discharged from hospital to care homes. We know that routine testing in care homes was announced on 16 May 2020, implemented in some care homes in June 2020, and we know that routine testing of healthcare workers didn't come about, as we've just been discussing, until 14 December 2020, implemented much later.

And as I say, those are just examples.

The Inquiry heard much evidence last week about the knowledge of asymptomatic transmission, that it was clearly -- that it had clearly emerged in February and March 2020 and there was ample evidence by April. And the question is this, Mr Gething: why didn't the Welsh Government take a more precautionary approach to decisions relating to testing throughout the pandemic that would have prioritised safety and saved lives?

A. We did take an approach that prioritised safety and saved lives, and we did that based on the knowledge we had at the time. And I've been through the real challenges of the state of knowledge and the advice we received from public health advising the science about

the risk of asymptomatic transmission, what it meant, and when that crystallised, in the sense of advice being provided to ministers, that there should be a different approach taken.

And in all of those I've been transparent in my evidence, in this module and in previous ones, about when and how that took place and about the fact that it was deeply uncomfortable. But the choices were made, based on the knowledge at the time. That knowledge is contested and I know that people say it should have been obvious but actually you can see the direct advice that ministers had at the time, and that's the advice that we acted on.

And, you know, that covers the choices that we made and why we made them in Wales. On a whole range of things, not just on asymptomatic testing. But I recognise it's an important issue for the Inquiry to hear evidence on and to look at the evidence that -- of the advice that we were providing, the choices that we made at the relevant time.

MS PARSONS: My Lady, may I just follow up on one point Mr Gething has just made? And it's with respect to the Welsh Government acting on advice.

The group would like to know, what advice was that specifically? What scientific advice told the Welsh

Government not to test asymptomatically?

A. We had advice from our Chief Medical Officer. We also -- it was covered in TAC and TAG advice notes at the time, about the value of testing at various points in time. We also had Public Health Wales testing advice as well. So this isn't an invention; there are multiple documents of advice at the time that set out that that's the advice that ministers in Wales received.

Q. That there was no clinical value in asymptomatic testing?

A. Now you're confusing two different things there. The advice was that this was not a route to use the testing resources on, because of the understanding about asymptomatic testing. I think you're confusing the statement made in the Senedd chamber, and I think the nuance or the cut and thrust of the debating chamber doesn't always translate well into trying to have a more forensic examination of it.

Mr Drakeford, as the First Minister at the time, was setting out that the advice doesn't say that we should do this.

I think if he had your time again, that would not be an exact phrase that he's used because I think it's been misused since then but it does cover the fact that the advice we received at the time was not to undertake

a course of asymptomatic testing. The knowledge we have now, we would it make different choices, and I think it's important to acknowledge that.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Parsons.

Mr Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Thank you, my Lady.

Mr Gething, good afternoon. My name is Leslie Thomas and I'm representing the FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.

Can I just check, can you hear me okay?

A. I can hear you and I can see you fine, thank you.

Q. Thank you. I only have one question for you, and it's this: in Dr Andrew Goodall's Module 1 statement he said:

"Prior to the Covid-19 pandemic, the Welsh Government statisticians and data scientists had minimal and *ad hoc* involvement in civil emergencies and the preparation for such emergencies."

My question is, to what extent did this lack of data make it difficult to address the health inequalities and disproportionate impact of Covid-19 on the black, Asian and ethnic minority communities throughout the TTI?

A. I think we'd be better equipped if there was further integration, and that happens through time during our

response to pandemic.

I'm not sure it would have made much difference, though, with respect. And that's because the inequalities that we talk about are not a secret. They're not unknown. The healthcare inequalities on the basis of socioeconomic outcome and the fact that black and Asian minority communities typically are over-represented in those least economically advanced communities is not something we don't know about.

It's like the fact that -- you know, seeing a police force with an overwhelmingly white population issuing fixed charges to 7% of its population, which is out of proportion. You shouldn't be surprised at that. A bit annoyed about it and want to do something about it, yes, but it's not a surprise.

I think, though, in future, a greater integration of data and statistics will help us in both understanding in a clearer way, rather than a broad "We know this is a problem" way, a clearer way about the scale of difference and then hope that will help to build some trust around why there are messages about how you want people to behave, as well as the risks.

I'll give you an example of that. Vaccination is a different topic but on vaccine you've got a loud campaigns to vaccinate teachers first, because there was

this impression that teenagers would go back to school, they're much like adults, and lots of vulnerable teachers would get Covid. It didn't actually happen.

Actually, if you look at the data, then taxi drivers and bus drivers were much more vulnerable, with a much more higher infection and mortality rate. And you and I both know, taxi drivers and bus drivers, there is a disproportionate number of people that look like you and me in that trade as well. So, actually, you can see where there was an issue where people were facing the public, what were the protections? Actually, they are more likely to have an infection rate. And also, given what we know about the relative mortality of Covid as well, we shouldn't be surprised that they had a higher mortality and ill health rate.

The challenge in having the statistics available is how useful they are, how reliable they are, and then how they inform policy choices.

PROFESSOR THOMAS: My Lady, can I just follow up with one thing that --

LADY HALLETT: Quickly, because the stenographer is going to have a fit.

PROFESSOR THOMAS: Very quickly, and it is this. My question is just slightly more nuanced than that, Mr Gething, because if there was only ad hoc data,

surely more targeted data means more targeted interventions. Surely you agree with that?

A. It could be. But the point I'd make in response is: having more targeted interventions could well have been helpful at a theoretical point. We found, though, that when you had targeted attempts, you need to be clearer about what they are. Is it about testing people? Is it about who you're contact tracing? Is it about cultural sensitivity in the way you're talking to people? Those things could work.

If you're talking about different rules, we found that in the first phase of the pandemic, having specific numbers of rules didn't work, and it -- actually it was unhelpful in people's understanding of what they were being asked to do.

But if you're talking about could it have then informed how services then responded in dealing with the public, I think the answer to that is yes.

PROFESSOR THOMAS: Okay, thank you.

A. I'm trying to be helpful.

PROFESSOR THOMAS: Thank you, Mr Gething, thank you, my Lady.

LADY HALLETT: Thank you, Mr Thomas.

Those are all the questions we have for you today, Mr Gething. You've probably heard me say it before but

I am acutely conscious of the burden we place on people like you, asking you to come up back for yet another module, and I promise you I have told the teams for future modules they must only ask to call a witness or place a burden on people like you if it is absolutely necessary.

So please forgive us for the repeated burden, thank you again for your help to the Inquiry, and I hope we can limit how many times we ask you to come back in the future. Thank you.

THE WITNESS: Thank you very much, my Lady, I'm sure I'll see you again though!

LADY HALLETT: I'm sure -- I can't guarantee -- I think I'm pretty confident there will be at least one more but we'll try to limit the ones after that, but thank you very much indeed.

MS CARTWRIGHT: Thank you.

LADY HALLETT: I shall return at 3.35.

MS CARTWRIGHT: Thank you, my Lady.

(3.19 pm)

(A short break)

(3.35 pm)

MS CARTWRIGHT: Thank you.

LADY HALLETT: Mr Drakeford, I'm sorry if we've kept you waiting for a long time.

THE WITNESS: Not at all.

MS CARTWRIGHT: Thank you.

Can I ask for Mr Drakeford to be sworn, please.

MR MARK DRAKEFORD (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Can you please tell the Inquiry your full name.

A. It's Mark Drakeford.

Q. Mr Drakeford, can we identify, please, your Module 7 statement. It's dated -- we then, sorry, move to page 97. It's dated 26 March of this year, and can I ask you to confirm, are the contents of that statement true to the best of your knowledge and belief?

A. They are.

Q. Mr Drakeford, it's right, isn't it, that this is your third occasion giving evidence to the Covid Inquiry?

A. It is.

Q. You've, I think, provided witness statements to every module bar Module 3 to date, and Mr Drakeford, I mean no disrespect to you by only dealing with certain topics that we have asked you to attend to address today, but all of your underpinning statement and evidence will form part of the work on Module 7 and your statement will be published in full.

So, with my apologies for the lack of context for

a number of these questions, can we then first identify, please, during the pandemic it's right, isn't it, that you were the First Minister in Wales?
A. I was.
Q. Thank you. And you became the First Minister and leader of the Welsh Labour in 2018?
A. Correct.
Q. And you remained as First Minister until 19 March of 2024?
A. That's right.
Q. And you remain an elected member of the Senedd representing Cardiff West and on 7 August last year you were appointed the Cabinet Secretary for Health and Social Services until 11 September 2024 when you were appointed as the Cabinet Secretary for Finance and Welsh language?
A. That's right. That's what I do now.
Q. Thank you, and that remains the position?
A. Yes.
Q. Thank you. Now, can I then, please, ask you a number of questions, please, but as you are aware, we have a small amount of time together today. And so the first question I want to ask you about is under the topic of decision making.
Now, you've provided the details of the COBR

meetings that you intended and I think, in fact, the first of which was 18 February 2020, although we know that there were other COBR meetings on 24 January, 29 January, and 5 February that the Minister for Health attended. Are you able to assist as to why you didn't attend those earlier COBR meetings, please?
A. The earliest of COBR meetings focused exclusively on the emerging evidence around coronavirus in other parts of the world and the health response across the United Kingdom. They were chaired by the Secretary of State for Health in the UK Government, and it was health ministers from the other administrations, who therefore joined those COBR meetings. Once the Prime Minister took over the chair of COBR, then those meetings were attended by the first ministers of the other three governments.
Q. Thank you. Can we, please, again on the theme of decision making, please, I want to ask you some questions, please, about the daily ministerial calls and to orientate these questions please could I ask for paragraph 44 to be displayed, which is at page 13. Thank you.
Now, you tell us that each morning, from early April, you were having daily calls at 9 o'clock with all ministers and the purpose of this was to ensure that

there was joined-up decision making in response to the fast-moving nature of the crisis.
Can I ask you, then, in terms of those meetings, it's right, isn't it, that that would not just have been Welsh Government Covid response that was being considered but, obviously, the four nations decision making? Or are these meant to represent the ministerial calls just within the Senedd?
A. These are simply Welsh Government ministers. You'll recall that by now nobody is in the building physically. Four of my ministerial colleagues are shielding and so are unable to leave home. I was very anxious that all my colleagues felt that they were as well informed as they could be about what everybody else was doing, this is such a busy period, which all my ministerial colleagues are discharging responsibilities that are directly relevant to Covid, and a call at 9 o'clock in the morning for everybody to make sure everybody else knows what they're facing that day, and the things they will be reporting back on the following day. Decisions are not made at these meetings. Those are made formally in the cabinet. This is an information exchange meeting, making sure all my colleagues feel they are fully informed about the work of the government.
Q. Thank you. And plainly, you're identifying all of the

work of the government.
Are you able to give us any idea as to how much of a priority was being given to the pandemic during these meetings in April of 2020?
A. At this point the meetings are almost entirely devoted to the pandemic. Not always completely. Brexit is still happening at this point. There are still negotiations about leaving the European Union. Every now and then we have to attend to that because it has legislative consequences for the Senedd, but I would have said that 90, or more, per cent of these morning calls in April are devoted to the pandemic.
Q. Thank you.
Mr Drakeford, can I take you, please, to an example of one of those meeting minutes, please, which is INQ000361519. This is -- when it's displayed, thank you. INQ000361519. Thank you.
Now, I think if we move through this email actually, that I think is reflecting a meeting of that day, which we can see what's being discussed. What I want to ask you is that we can see that a range of topics were being discussed at that meeting including second home rules, finance, the agenda for the next meeting, including food banks and funding for the local government.
So the question I want to ask, please, is: were

these daily meetings giving sufficient focus on testing issues in the April time, please?

A. Well, you'll see from the top of the page that testing was discussed at this meeting, "Pressing ahead with work currently under way to increase testing capacity". So testing would be a very regular theme in these meetings. There would be number of very regular themes. PPE would be a very regular theme. Testing would be a regular theme. Ventilators, which we now don't talk so much about but at the time was a real pre-occupation as to whether we would have sufficient ventilator capacity. Staffing capacity. We know that people are falling ill in our key public services. So those four themes you'd see, I would think, very regularly, reported on a daily basis.

Q. Thank you.

That can be taken down from the screen.

Then, again in terms of meetings, can I ask you, please, Mr Drakeford, the first Covid-19 positive case was reported in Wales on 28 February 2020, and it appears as if the next meeting was not until 16 March when the cabinet next met. Does that fit with your recollection as to broadly being correct in terms of first Covid case in Wales and then the next occasion when the cabinet met?

A. I think you're right about the date of the first Covid case. Cabinet meets weekly so it would not have not met until 16 March. Cabinet meets every Monday, would have been meeting every Monday during those three weeks.

Q. Thank you. So, in terms of -- your evidence is the frequency of the meetings remained the weekly meetings of cabinet, and that would have been the same in February of 2020?

A. It would have been, yes.

Q. Thank you.

Can I then, please, move to a different topic, please, and can we display, please, first of all, paragraph 175 of your Module 7 statement, please, which is at page 49. Thank you. Actually, it's page 50, sorry -- no, it's not page 50, it's page 51, please.

Now, it's questions really on the theme of asymptomatic testing, and I think you're well aware, Mr Drakeford, that there is an issue and concern in particular from the Covid Bereaved Families for Justice Cymru about the delays in introducing asymptomatic testing at an earlier stage of the pandemic. So can I capture, and so there's clarity from your perspective, as to why asymptomatic testing was not introduced sooner, bearing in mind, perhaps if we can use this as an example, there was capacity of 2,100

tests, for example, on 5 May 2020?

A. Well, my recollection of the asymptomatic testing issue was this: that at the very start of the pandemic the advice that we receive was that during MERS and SARS, the most recent examples, there'd been very little asymptomatic infection and even less evidence of asymptomatic transmission. And in the very early days the advice was that there was no reason to expect that this form of coronavirus would be different.

Over time, however, as Chris Whitty -- Professor Chris Whitty -- says, slowly evidence begins to accumulate, Dr Frank Atherton says that gradually evidence begins to accumulate, that there is more asymptomatic infection. And beyond that, there becomes evidence that asymptomatic transmission is taking place. But this is an evolving pattern in which evidence slowly moves in that direction, and the Welsh Government's policy position follows that evidence.

So the early evidence is that you would not divert tests that you would otherwise use for symptomatic people to test asymptomatic people. And by the middle of May -- it's not until the middle of May there is evidence that there is greater utility to be had from greater use of asymptomatic testing.

But well beyond that, you know, in July -- on 9 July

the World Health Organization still says that there is inconclusive evidence about asymptomatic transmission, and in August of that year, Chris Whitty is writing to the House of Commons Health Select Committee saying that the evidence is still not concluded on that matter.

Q. Thank you.

Can I then, please, just ensure that there's complete clarity as to the sources of the advice and the scientific advice that was informing your decision making linked to asymptomatic transmission of testing that you've just plainly given quite a lot of information about. And so where were the sources of scientific advice that you were relying upon to inform the policy decisions around asymptomatic transmission please?

A. Well, directly to ministers there would be around four or five layers of evidence. My Lady, this is a sort of funnel, in a way, isn't it? You know, at the top end of the funnel there are the scientists who are directly working on the research and the evidence. By the time ministers see evidence, it's been distilled down to the evidence that you get, which tells you what other people are working on and concluding.

So that evidence would come directly to ministers via the Chief Medical Officer, via the chief health

scientific officer, via the Chief Executive of the NHS. So I would meet all of them weekly. And then you would have the evidence from the Technical Advisory Cell and the Technical Advisory Group, and they themselves are linked into SAGE and SPI-M and all the other form -- but ministers aren't looking directly at SAGE agendas and SAGE papers, you're relying on the distillation of that that comes to you through the people who advise you directly.

Q. Thank you. Can I ask you then when, obviously, the decision making and the policy changed following on from 18 May 2020 for asymptomatic testing, there is certainly a proportion of evidence that suggests that there -- so there was capacity, more capacity for testing than was being utilised in Wales and particularly up to the August time. Was there any thought given as to the better utilisation of the tests that were available in Wales to utilise for testing, to give healthcare workers, in the context of asymptomatic transmission?

A. Well, I think there are two very distinct halves in this time period. In the initial time period all the effort is going into trying to increase the volume of testing that's available to us. We don't have enough tests and we're trying to increase the number that we can deploy.

There is some frustration. You've heard it directly

from, but you'll have seen the evidence from Vaughan Gething particularly, that we then don't appear to be using all the tests that we've got available.

Now, he's offered three explanations for that. First of all, we're told that you don't -- you shouldn't plan to use all your tests for planned use because on any day, there will be some emergency in the Covid context where you will need some spare tests that you can apply to people who you weren't expecting.

Secondly, the advice was you can't run the system at full throttle every single day. You will have machinery that breaks down, you will have staff that become exhausted, you will have supplies of reagents and so on that you will run out of. So yes, you can have 5,000 tests in a day, but that's if every single part of the system is going flat out and you can't plan to do that every day.

And then thirdly, you need some tests for non-Covid purposes.

So I think there are some very forensic questions asked by the Health Minister, 21 separate questions he asks as to why we appear not to be utilising the full capacity of tests we've got and those are the answers that he gets.

Later on, once you get into June, the reason why the

number of tests we have available is not being taken up is much more to do with the fact that there is far less Covid in circulation, you know. On many days in June you're talking about 35 cases across the whole of Wales. And yet, luckily by now, we've got 12,000 tests available. And in a way, that's, thank goodness for that, because by the time we get to the autumn we're very glad indeed that we have built up the tests we have available in that way, even though they weren't needed in the height of the summer.

Q. Thank you. Can I then ask a question, please, linked to the liaison between the Welsh Government and the United Kingdom Government and can we please, to give some context to this question, please, look at your paragraph 53 on page 16. Thank you.

Paragraph 53. Thank you.

I think this is under your section where you deal with four nations engagement and we can see from this paragraph that you detail that you attended the majority of the Chancellor of the Duchy of Lancaster calls, and that these would consider issues relating to Test, Trace, Protect, where appropriate, and then you provide a context of the various calls and the like.

And so can I ask as to a general overview, whether the four nations collaboration was sufficient and

suitable in your judgement at that time, please?

A. Well, I think those meetings in relation to TTPs have two main purposes. One is a problem-solving purpose. So I know the Inquiry will have heard evidence earlier today about periods when the Lighthouse labs weren't able to operate at full stretch and there was a reduced number of tests available.

So when problems arose, the weekly calls with Michael Gove at the Chancellor of the Duchy of Lancaster were a chance to surface those problems and to make sure they were being properly attended to. And then the other purpose they served was a good-practice sharing purpose, because we are all of us trying to make sure that we reach all the people we need to reach, and as we know, not all parts of the community are as easy to reach as others, all parts of the United Kingdom are trying different things, and those meetings served as an information exchange so we could learn as rapidly as we could from one another.

Q. Thank you. Can I ask whether you identified any issue that we heard a little earlier from Mr Gething, particularly when I was asking questions about the later date when Wales introduced the asymptomatic testing on 18 May, which was a few weeks after the United Kingdom had done so. Was there any frustration from your

perspective, ever, that there wasn't the shared communication on important and key decisions?

A. Well, inevitably, there were frustrations. They are often borne, as I think Vaughan Gething said to the Inquiry, because everybody is working flat out, everybody is dealing at full stretch with all the things we want to, and there are inevitably going to be things that go wrong.

But they do cause frustration, and sometimes, rarely, but sometimes, they cause risks as well. So if you wanted my example of that, it would be that early and sudden arrival of a testing site at Cardiff City Football Club, unknown to the Welsh Government, the risk there was that no plan had been made for the results of those tests to be fed back into the Welsh NHS system.

So your GP, for example, would not have known that you would have had a Covid test at that centre, because there was no route for the data to be transferred into the patient record.

Now, I think that potentially caused risk to people. Now, it was sorted out, it was put right and so on, and I'm happy, you know, and I'm still content to say that things that went wrong were not because anybody was -- had malign intent, but because everybody is trying to do everything too quickly, but in all of that, sometimes

risks do occur.

Q. Thank you. And Mr Drakeford, thank you for identifying that issue linked to the results in that centre then not finding their way onto the patient record and the GP records. Are you able to give us some idea about how that problem was fixed, and over what time frame?

A. Well, that problem was fixed by the clever people who do understand how to make one system talk to one another. It was done pretty rapidly over just a -- my recollection is only over a couple of weeks.

So these were problems that were fixable but had there been more notice at the beginning -- that was a, you know, a helpful development, to have more tests available in Wales, had we understood more about it in the beginning, we could have stopped that from beginning a problem that had to be put right.

Q. Thank you.

Can I move on, please, Mr Drakeford, to a short topic on public communication, please. And can we have displayed before you your paragraph 315, please. It's internal page 90. There's a section before this that gives the full context around communication. But I want to just expand some questions, please, following this statement. You say as follows:

"On the whole, I consider that public communication

in respect of Test, Trace, Protect worked effectively. As noted above a critical area of challenge was ensuring clarity between the position in Wales and that of England, particularly along the border. As the pandemic progressed, and the national media gained a greater understanding of the areas of devolved competence, this did improve but still remained a challenge throughout. There were also areas of challenge which were presented by particular characteristics of the population of Wales, such as the need to operate within a bilingual environment, and the higher percentage of older people than the UK as a whole (who were more likely to be digitally excluded) ..."

Which you have addressed also in this statement.

And can I ask you then, please, building on that analysis, please, are you able to assist us on how socioeconomic and cultural factors were considered in shaping the communication strategies for testing and self-isolation, particularly in deprived and ethnically diverse communities?

A. Yeah, well, thank you, Ms Cartwright.

So, one of the key reasons why it was decided that we would have our own system of TTP in Wales is because of language. It seemed to me that if you're going to get a call from somebody asking you to self-isolate and

being able to answer questions from you as to how you could then protect yourself, you would be more likely to act on that advice if it came to you from someone who knew the area that you lived in, who was able to pronounce the name of the town or village you were living in. And I couldn't see how that would effectively be done from a call centre in Billericay. You know, in the part of Wales that I come from, there's a village called Llanfihangel-ar-Arth. I don't know how many people --

LADY HALLETT: Are you going to explain to the stenographer?

THE WITNESS: I'm sorry, I'll do my best. I couldn't see how somebody in a call centre elsewhere would have been able to have communicated effectively -- even if that person was happy to speak in English rather than their preferred language, which would very likely, in that part of Wales, be in Welsh.

So, you know, the decision to have a bilingual service provided locally is very much part of the answer to part of your question. But then there are other groups who we need to reach, and you've heard earlier about the decision of the Welsh Government to fund a cadre of frontline workers, often drawn from the black and minority ethnic communities, who could go door to door, who could be trusted intermediaries between people

who maybe didn't completely understand or trust what was being asked of them, and to be able to be that bridge between the service we wanted people to use and the lives that people led every day.

MS CARTWRIGHT: Thank you.

Now, the paragraph I just took you to dealt with the issue that you've identified that's particularly pertinent in Wales, regarding digital inclusion.

Mr Drakeford, could I seek any assistance you can provide, relating to -- and we know the Covid-19 app was available after 24 September 2020. There is information to suggest that there was low uptake in Wales.

Can I ask, please, to be displayed INQ000574818.

It's a map, if you were following of the evidence of Mr Gething, that I asked about by reference to uptake to the Covid-19 app.

If it could be expanded, please.

I've asked all the Welsh witnesses today if they can assist with what appears to be quite a significant trend in relation to the uptake of that Covid-19 app, of an almost universal low uptake at the 16-20% and, in a pocket of Wales, even lower, at 11-15%.

Are you able to assist us as to why it was that there was this low uptake of the Covid-19 app?

A. Well, Ms Cartwright, if this map had been presented to

me in one of my research methods classes, my advice would probably have been to check the data, because I don't think that I necessarily believe what I'm seeing here.

So the first thing I would have done would be to make sure that this map is comparing like with like, that it's drawing its information from the same sources, that we can be confident that this pattern really is a reflection of use, rather than, you know, an artefact of the way in which information has been collected and is being presented.

If I was doing it from a research methods perspective, that's the first question I would have asked about this map.

If it is a genuine representation of differential use, as starkly as it seems to be there, then I think there are two or three explanations that might help to cast some light on it. One is the digital exclusion example. Wales has a higher proportion of its population in over 65, 75 and 85, and, as we know, the older people get, the less familiar they can be with some of those ways of doing things.

Secondly, we didn't rely on the app to the same extent in Wales. You know, we had a very successful TTP service that people knew about.

And I think the third reason is that getting the app available to Wales, and getting it to work for Wales, you know, getting it to be -- have a Welsh language capability had been quite a struggle. So although we decided to go in with it, hours and hours were taken up of Welsh Government's officials' time in trying to make sure that the app genuinely reflected Welsh needs and circumstances. And I think amongst the reasons, as I say, if the map is a genuine reflection, which would be my first question, then I think those reasons are amongst them.

Q. Thank you.

Thank you, that can then be taken down, please.

Can I then ask a question, please, by reference to your paragraph 203 of your statement, please? It's internal page 59 of your witness statement.

Thank you.

You detail within the statement that:

"The social and economic impacts of self-isolation were at the forefront of our consideration of the 'Protect' element of Test, Trace, Protect. Support in the form of financial, practical and emotional assistance was funded by the Welsh Government. This included support for individuals who were isolating as close contacts, having been contacted by Test, Trace,

Protect tracers. This support was provided by every local authority in Wales."

Can I ask you in respect of that, how did the Welsh Government ensure that information about these support schemes reached vulnerable and marginalised groups, particularly those with language or trust barriers?

A. Well, we would have used universal means of making sure people knew it, so the Chief Medical Officer wrote regularly to every single person on the shielding list, for example, and then that cascades to people's families and so on.

There are digital form, you know, the local authorities all have their websites, all with lists -- and the amount of practical assistance that was available was a huge range, from people who needed help with buying food or having medicines delivered to having their dog walked. I mean, I remember being very struck during the pandemic as to how important it is to people, particularly people who live alone, and who now aren't allowed to go out, that somebody comes and helps them to help them look after, you know, another sentient being that they have a really strong relationship with. It seems odd in the middle of a global pandemic that dog walking becomes important but, in a practical sense, it really matters.

Now there then is the question you asked about how do you reach those communities where maybe levels of trust are less? You've got to find intermediaries who are trusted, so I spent a number of weekends with Muslim Doctors Cymru, a fantastic group of young doctors who would go to mosques, and explain to people as they came in why it was important that they would be vaccinated, why they ought to follow the advice they were given. And faith groups were very often, we found, a way into the lives of people who might have hesitation in acting on information that simply came from government sources.

Q. Thank you.

And perhaps can we just display again that page, thank you.

You've obviously just identified the engagement you had through the mosques. We can see at paragraph 200 you identify that you sought input from a wide range of stakeholders, including local authorities and the third sector, in developing accessible testing provision.

Obviously you've clarified one source of assistance, but is there anything else you can assist by way of clarification as to engagement with ethnic-minority-led health and community organisations as part of these consultations, please?

A. I wonder, my Lady, whether I might just make one general

point here, and it came partly from my own experience of being the Health Minister during a large measles outbreak in the Swansea area of Wales, where we would write to families, sometimes knowing that they were from different backgrounds, and what I think I realised is -- you know, I feel like I have been very fortunate in my life, that, on the whole, I've lived in a context where if you are contacted by the state, you think that's because it's got a benign intention behind it. A letter from the council is going to be telling you something you need to know. We were writing to families who came from other parts of Europe, now, where a letter from the state is something to be worried about.

And so instead of opening it and following the advice, people were putting it on the mantelpiece and making sure they didn't open it at all. So one of the more general lessons, I think, to be gained from this experience is that some of the ways in which we try to communicate are very, very culturally driven. They come because of the way we think about things, and we don't always realise that that way of doing things may evoke a very different response from people whose experience has been otherwise.

And I think, I hope we took a bit of that into our Covid response, but I think we could have -- I think

it's a more general lesson about not assuming that something as simple as a letter, which we think of as being a good way of getting hold of people and translating it into the language and so on, may have the opposite effect than the one that you're intending.

Q. Thank you.

And finally for my questions, please, Mr Drakeford, can we please move to your lessons learning/reflections on facing a future pandemic, please, and paragraph 333. It's page 95, please. Thank you.

Now, you detail at paragraph 333:

"My view is that the first question that the Inquiry might ask is whether the Test, Trace, Protect (or its equivalent) system was the correct system to use in response to a pandemic of this scale. I consider that it may not have been the correct answer to make use of a conventional public health approach to dealing with communicable diseases, that were tried and tested and successful in those shorts of outbreaks [sorts of outbreaks, I think that should be] that public health technicians were used to dealing with, by simply replicating the same thing on a larger scale."

Can we have complete clarity about what you're saying and what your view is here, Mr Drakeford, particularly informed as the fact that you were the

First Minister that was intimately involved in what was taking place and decision making.

A. Well, thank you, and thank you for the invitation to reflect at the end of the statement on any lessons that I think might be drawn, and it's a "might". I don't want to say it is a lesson but I think both at the time, and thinking back, I do ask myself the question whether the industrial scale of contact tracing, everything that we did, whether we got an adequate return on all of that activity in terms of public health protection. That's my first question. There is a very interesting TAC paper that came the way of the Welsh Government, I think in March 2021, that said contact tracing does work, but by far the largest effect comes from contacting the index case and getting them to isolate. And the additional protection you get from all the other contacts that you make is relatively marginal. And yet we were doing it on this huge scale.

So I just think there is a question that is worth exploring as to whether or not, just taking what public health physicians knew, in that measles outbreak, in that tuberculosis outbreak, and then thinking that that would work, given the scale of challenge faced by Covid, whether that turned out to be the right assumption to make.

And then, I think the other thing that I would -- was concerned about and would be concerned about, is because we were putting such an enormous effort into the TTP system, did that prevent us from thinking about doing things differently? Were we so invested in making this work that we didn't have what is sometimes called these days a red team, isn't it, a group of people who because you not is that system working well, but is that the right system to use at all? Were there other things we might have been able to do?

We never really did ask ourselves that question because we were so invested in making the system that we had work and I think in future, maybe it would be good to build into a reaction, you know, a bit of challenge so we don't just take the things we know about already. And public health physicians knew about contact tracing. And then they decide -- you know, they advised us that this was the right way of responding to Covid.

LADY HALLETT: Thinking of other options, Mr Drakeford, I don't know if you heard the evidence about the ZOE App from Professor Spector which I gather was taken up to an extent in Wales.

A. Yes.

LADY HALLETT: But basically, the principle there is, it's not test and trace, it's a symptom tracker, and then

when you know what the symptoms are, including loss of smell and taste, which as you know, weren't originally thought to be symptoms, then people got symptoms, you'd tell them to stay at home.

A. Yes. Well, I think that's a very good example. I used the ZOE App myself every day. The first thing I used to do in the morning was to put -- in Wales the reason that people did it, I'm not saying this isn't true elsewhere, but certainly in Wales the best appeal to make to people is not do this because it'll be good for you; it's do this because you'll be helping somebody else. So the reason people filled in the ZOE App is because they knew that if you did that, that would provide information that would, you know, help other people to know what was going on.

So I think that is a very good example of something else that was happening, but it was slightly to one side of the real effort, which was making TTP work.

MS CARTWRIGHT: Thank you.

And finally for my purposes, please, Mr Drakeford, you'll be aware that the first module report has already been published, and it's just a brief question on one of the conclusions in that report, paragraph 5.68, and obviously you'll be aware that the UK Government and devolved administrations have been identified through

that first report on preparedness that could and should have invested in infrastructure in advance of the Covid-19 pandemic but had not done so. And if we follow it through to the end, we can see the massive cost to the nation of building test and trace systems from scratch, the building blocks and essential structure of the test and trace systems established by the United Kingdom Government and the devolved administrations during the pandemic should have been maintained, so that these systems can be rapidly restored and adapted for use in the event of a future outbreak.

I appreciate you're no longer the First Minister but you were up until 2024. Are you able to assist us why the building blocks of test and trace system established during the pandemic, particularly in Wales -- well, first of all, if any had been maintained, please say so, but essentially for those that have not been maintained for future deployment in another pandemic, why that is the case?

A. Well, to answer that question directly, and it's part of what I think is quite a challenge, in the first sentence of the recommendation, because essentially, the recommendation is that governments should maintain a series of stranded assets, things that you are not using, but you are maintaining and spending money on in

case you may need them at some point in the future. And in the world of practical politics, that is a very hard thing to do.

I mean, when I was the Health Minister, I agreed to spend a significant sum of money on Tamiflu, which then after five years, had to be written off because it was no longer -- you know, its usefulness decays over time, and we were very, very heavily criticised by opposition parties and other people in the public for such a waste of money you know, we'd invested in this, and there it was, it was useless, and that was a very hard thing to sustain in the political world, investing in things that cost you money, not because they're useful to you, but because they might be needed in the future.

In terms of the things that we did invest in, and whether we still have them, we do to a certain extent. In many ways the human resources, I think we do still have, and, you know, we've learned a lot about how we can adapt the human resources we have, and we used that very successfully in TTP, in using our local government colleagues who were not able to work in their normal jobs but were good in talking to the public.

I heard your question, I think to Jo-Anne Daniels, about the Newport lab. I think that's a much less satisfactory story. The Public Health Wales part of

that does continue to operate.

The Lighthouse labs were jointly funded by all four nations, because we could have chosen to have our Barnett share and done our own but we chose instead to have a single pot and we could all benefit from it, and we did all benefit from it. You know, Wales was very glad to have access to it. But once the contract ended, the UK Government alone decided not to continue to fund it. So all that investment of the public purse had made in those facilities evaporated at that moment.

Had the public sector directly owned and run those facilities, they would still be available. And I think there's a bit of a lesson there too, about -- I know it was all hands to the pump and you had to use, you know, other -- but the contractual basis of some of those facilities meant that the public return on the money that was invested was very short-term indeed and, done a different way, could have had a much longer set of benefits for the public.

MS CARTWRIGHT: Mr Drakeford, thank you for answering my questions.

My Lady, there are Core Participant questions, thank you.

LADY HALLETT: There are. I think just from Ms Parsons.

Round the side of the pillar, Mr Drakeford, if you

want to see where Ms Parsons is.

THE WITNESS: I can see, thank you.

Questions from MS PARSONS

MS PARSONS: Thank you, my Lady.

Good afternoon, Mr Drakeford. I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. I want to ask you about the Welsh Government's understanding of asymptomatic transmission. And you summarise that position at paragraph 75 of your witness statement, and we don't need to turn it up, but I understand the position in short is that up until April 2020, there was, you say, insufficient evidence of asymptomatic transmission upon which to base operational decisions. Is that your understanding?

A. That's right.

Q. So there needed to be sufficiency of evidence, for example, to introduce asymptomatic testing of healthcare workers, and so on; is that right?

A. Ms Parsons, I think that there needed to be sufficiency of evidence to prioritise the use of tests for that purpose, rather than other purposes that were also required at the time.

Q. A matter of priorities.

I know you're familiar with SAGE's precautionary approach, Mr Drakeford, and given that approach, do you

think the Welsh Government ought to have taken a precautionary approach in relation to asymptomatic testing?

A. I think the Welsh Government attempted to follow the evidence as it was presented to us. I don't think we were in a position to be wiser than anybody else about the nature of asymptomatic infection or transmission, which obviously evolved over time. The decisions we made were made in the light of the best evidence that was given to us about whether or not diverting tests for asymptomatic use was justified by the conditions of the time. And that changed over time.

Q. So what is your answer to whether the Welsh Government ought to have taken a precautionary approach?

A. Well, I believe we did take a precautionary approach. And then the question is: could we have taken a more precautionary approach? And I don't think the evidence would have justified us in doing so.

Q. We know, because of the Welsh Government's opening for this module to the Inquiry, that they've accepted that they were late on their policy in terms of testing those being discharged from hospital, so I think we can say that that wasn't a sufficiently precautionary approach there; is that fair?

A. I think what the Welsh Government's statement says is

that there was a delay which ought not to have been as long as it was between a policy decision and the guidance being published.

So in that case the decision was made on 15 April and the guidance was published on 29 April. And the Welsh Government's statement acknowledges that that gap should have been shorter.

Q. On the subject of gaps, though, Mr Drakeford, I think what's coming over from the Welsh Government witnesses is that the evidence, in their view, began to change in April/May time, hence the policy to test in care homes, but the policy in respect of healthcare workers didn't change until November 2020, and even, in practice, March 2021. So that wasn't a precautionary approach either, was it?

A. Well, I think that's more linked to evolution of technology, isn't it? Healthcare workers were tested from the very beginning. The first healthcare workers in Wales were tested on 7 March. And so it's not that healthcare workers aren't being tested until the late autumn; it's a question about whether you can use lateral flow tests accurately and reliably on a wider scale.

There is a gap -- I heard Vaughan Gething answer questions about the gap between the policy of the Welsh

Government being determined and its implementation on the ground, and I think Vaughan acknowledged that there were gaps in the advice that came to ministers about the length of time that was taking.

But I don't think myself that the policy was particularly late in being developed.

Q. Sorry to come back on this, Mr Drakeford, why not? Why do you say that's not late? The evidence was there, many say well before April 2020 and, on your own account, by May, when you changed the policy for healthcare workers. Why is November -- November through to March -- not late?

A. Well, I think I'm not agreeing with the basic premise of your question, because -- I may be misunderstanding, and apologies, if I am -- I think what you're saying to me is that it took from March to November to have a policy of testing healthcare workers. I simply dispute that. We were testing healthcare workers from 7 March onwards.

Q. And I apologise, Mr Drakeford. It's my fault.

Routine testing asymptomatic healthcare workers. That's the key. I'm so sorry, that's been the heading for all of my questions, in fact: asymptomatic transmission and asymptomatic testing.

That came in in the November as a policy -- sorry, that was discussed in November but it didn't come in

until 14 December?

A. Thank you. I understand the question better now.

And as I say, I think that that is related more to the availability of a different sort of test. There was a lot of debate in Wales as to whether or not those tests could be used in that way. Would they be sufficiently reliable? Would people have confidence in them? And it did take until later in the -- in that consequence of events for us to have arrived at a point where we thought that those tests could be used, and therefore that asymptomatic testing would be possible at the scale and in the way that it was after November 2020.

Q. But just before we move on from this, of course, Mr Drakeford, we've been discussing that Wales didn't use up its capacity of testing, in any event, throughout 2020.

A. Well, as I've explained, I think there are two phases in that. The autumn that -- I beg your pardon, the summer phase is because there isn't a demand for testing. The gap between tests available and take-up of tests in the early period was raised, and, you know, I would say very pointedly raised, by the Health Minister with officials and he was offered the explanation that he was offered.

Q. Lastly, and briefly, if I may, Mr Drakeford, your

statement highlights the characteristics of Wales, its size, political structures, strong social partnerships, and so on, and it highlights them as advantages during the pandemic response, and you underscore distinctive decision-making principles in your witness statement that prioritised trust and equality. That's at paragraphs 19 to 24. We needn't turn it up. I'm sure you know what I have in mind.

But throughout the pandemic, Mr Drakeford, there are a number of delays in the implementation of testing policy as compared to England. I appreciate, of course, it's a devolved matter, but nevertheless, the delays are consistent and striking. By way of example, routine testing for care home patients on discharge from hospital, routine testing in care homes full stop, and routine testing of healthcare workers, which we've already discussed.

Given the characteristics that you've highlighted, as positive characteristics which inform good decision making, why was there such a delay in testing decisions that I've just outlined?

A. Well, I think there is a general difference in approach between the way in which UK ministers made decisions for England and the way Welsh ministers made decisions for Wales, and that disguises something which I think

doesn't completely emerge in the question.

In my experience, the approach in England was to announce first and then plan. So you can announce that something is going to happen, but if you don't have a plan for making it happen, it actually doesn't happen. So the fact that somebody in England says everything is going to happen from next Tuesday, believe me, is no guarantee that it was happening from Tuesday.

In Wales, we took the opposite approach: we planned first and then we announced. And sometimes that makes us look like we are later doing things than was happening elsewhere, but I believe that our method was more effective. It delivered better on the ground, and it certainly, I think, explains why there were higher levels of trust in Wales, between decision makers and those affected by them, than turned out to be the case in England.

Q. Just so I've understood your evidence, Mr Drakeford, does that effectively mean that you're suggesting that even though England announced policies earlier, in fact it was just that they introduced them, in reality, at the same time as Wales?

A. Well, I think the gap is not the gap that you suggested in your earlier question by saying, you know, something was announced in England and then two weeks later

something happens in Wales. I think the gap is considerably less than that in practice.

MS PARSONS: Thank you.

Thank you, Mr Drakeford.

THE WITNESS: Thank you.

MS PARSONS: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Parsons.

That completes the questions we have for you, Mr Drakeford. I don't know if you heard what I said to Mr Gething but I am very conscious of the burden we place upon you. I know you are still extremely busy. I've checked. I can't give you any guarantees that we're not going to ask you to assist us again but I promise you, the teams are very conscious that we shouldn't place another burden on you unless it's absolutely necessary.

Thank you so much for your help today and for your thoughtful evidence.

THE WITNESS: Appreciate it. Thank you.

LADY HALLETT: Very well, I shall return at 10.00 tomorrow. Thank you.

(4.30 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X