Witness Name: Rt Hon Mark Drakeford MS
Statement No: 1 in Module 7
Exhibits: 143
Dated: 26 March 2025

UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF THE RT HON MARK DRAKEFORD MS

I, Mark Drakeford, provide this statement, my first in Module 7 of the Inquiry, in response to a request under Rule 9 of the Inquiry Rules 2006 issued under reference M7/MarkDrakeford/01.

Preamble

1. I want to acknowledge at the outset of my statement, as I have done with all other statements, the unprecedented impact the pandemic has had on people across Wales.

2. The pandemic touched the lives of everyone in Wales: my own, my colleagues, our communities, but none more so than the many families who lost loved ones. I'd like to take this opportunity to express my personal sympathies, to those affected, and to all who sadly lost loved ones.

3. I was and remain extremely grateful for, and very proud of, the efforts and commitment of the people of Wales in keeping Wales safe by following guidance and complying with the unprecedented restrictions on our daily lives. I am also grateful for and proud of our Welsh public services; their efforts and commitment were unquestionable. I would also like to thank my civil service colleagues for their contribution and support in delivering the Welsh Government's functions and responsibilities.

4. Sadly, too many families have lost loved ones. This cruel virus has stolen lives, and it has left their loved ones with questions, which they rightly want answered. I, and the Welsh Government, are committed to this inquiry.

5. I understand that a comprehensive corporate statement on Test, Trace, Protect has been provided by the Welsh Government. The information I have provided in this statement will be structured as noted below and will relate specifically to my role as First Minister for Wales in respect of issues relating to this module:

    a. **Part A:** Introduction and overview of my role and the relevant structure, people and processes in relation to Test, Trace and Protect;
    b. **Part B:** System Readiness;
    c. **Part C:** Key legislative changes and chronology of key decisions between January 2020 and June 2022;
    d. **Part D:** Equalities;
    e. **Part E:** Testing;
    f. **Part F:** Test, Trace, Protect;
    g. **Part G:** Tracing;
    h. **Part H:** Isolating;
    i. **Part I:** Other Decision-Making Relating to TTP;
    j. **Part J:** Public Communications;
    k. **Part K:** Data, Modelling and International Comparisons;
    l. **Part L:** Lessons Learned / Facing a Future Pandemic.

Part A: Introduction and Overview

6. I was born and brought up in Carmarthenshire and attended Queen Elizabeth Grammar School, I studied Latin at the University of Kent and graduated from the University of Exeter as a social worker. I moved to Cardiff in 1979 and worked as a probation officer and a youth justice worker, and as a Barnardo's project leader.

7. From 1991 to 1995, I was a lecturer in applied social studies at the University College of Swansea (now Swansea University). I then moved to the University of Wales, Cardiff, renamed as Cardiff University in 1999, as a lecturer in its School of Social and Administrative Studies. I was promoted to Senior Lecturer in 1999

and appointed as Professor of Social Policy and Applied Social Sciences in 2003. I continued in post, alongside my political work, until my appointment as a Minister in 2013.

8. From 1985 to 1993 I was a councillor for South Glamorgan County Council and served as Vice-Chair of the Education Committee during that time. Following Mr Rhodri Morgan's appointment as First Minister in 2000, I became a special adviser on health and social policy and later served as the head of the First Minister's political office. I succeeded Mr Morgan as the Assembly Member for Cardiff West when he retired in 2011. Immediately after, I became the Chair of the Welsh Assembly's Health and Social Care Committee and of the All-Wales Programme Monitoring Committee for European Funds.

9. In 2013, I was appointed as Minister for Health and Social Services in the Welsh Government and served in that role until 2016. Following the May election of that year, I became Cabinet Secretary for Finance and Local Government. Later in 2016, I assumed responsibility for the Welsh Government's Brexit preparations. I became First Minister and Leader of Welsh Labour in 2018. I was appointed as a Privy Counsellor on 10 January 2019.

10. I remained First Minister until I tendered my resignation to the King on 19 March 2024. I remain an elected member of the Senedd, representing Cardiff West and on 07 August 2024, I was appointed the Cabinet Secretary for Health and Social Services until 11 September 2024 when I was appointed as Cabinet Secretary for Finance and Welsh Language.

Portfolio responsibilities

11. My responsibilities as First Minister during the relevant period are set out in exhibit **MD-7/001 - INQ000216614**. I was primarily responsible for the formulation, development and presentation of Welsh Government policy; this did not change during the pandemic period.

12. I was accountable to the Senedd which exercises scrutiny of Ministerial decisions, policy, government bills and subordinate legislation via its plenary proceedings and through the work of its committees and sub-committees.

Decision-making principles of the Welsh Government during the pandemic

13. I have set out in my M2B statement, which I exhibit here as **MD-7/002** - **INQ000371209** the decision-making principles of the Welsh Government during the pandemic. It is not my intention to rehearse the totality of that evidence here, but in order to assist the reader, I have set out below the overarching principles about the way in which the Welsh Government responded to the pandemic.

14. I consider that there are a set of distinctive values and an approach to the exercise of government decision-making which shaped successive Labour governments in Wales, long before the pandemic.

15. We sought to carry through those values and that approach to government decision-making during the pandemic. These values were shared across the Welsh Government Cabinet and, to a significant extent, across the wider public sector in Wales and which included a belief that good government is a force for good, in the lives of the people of Wales, that the relationship between individual and public services should be one of citizenship and not consumerism and that seeking to maintain a high level of trust meant that we had developed a preference for public services to be owned by the public, run by public servants, and animated by a commitment to public service.

16. By way of example, we were offered an opportunity by the Secretary of State for Health to become part of the UK Government's private commissioning for the Test, Trace and Protect service but we declined. I was concerned to ensure that when people in Wales were contacted by the service to ask about highly personal matters, they would have confidence that the person on the other end of the phone had some understanding of their local context, could discuss matters in their preferred language, had a good knowledge of local geography and service organisation and was motivated by a sense of public service. I will return to this decision in further detail later in this statement.

17. The Test, Trace, Protect programme also demonstrated a further core value we were striving to achieve, namely that the relationship between the state and the citizen should be one of co-production. A highly trusted and effective public service works best when the person using a service is seen as an asset, not as a problem to be solved. The expertise never lies solely on the side of the provider – the job of a teacher is not to pour knowledge into an empty vessel. It should be a reciprocal relationship between the contributions of the public service and the service users. This shaped our approach to practical issues in a crisis.

18. In Wales, the Wellbeing of Future Generations (Wales) Act 2015 promotes equality as an objective for society, not simply equality of opportunity. From the beginning of the pandemic, we saw the differential impact of the pandemic on different parts of society and quickly realised that many vulnerable people would be more severely impacted by all aspects of the pandemic. Wales started the pandemic already characterised by deeply entrenched health, economic and social inequalities. We sought, as far as we were able, to ensure that government action did not aggravate those inequalities and supported those approaches to reduce or reverse their impact. I return to this issue in substantive detail in Part D below.

Characteristics of Wales which affected decision-making

19. The size of Wales as a nation and the stability of relationships between individuals and public bodies were hugely important to our decision-making during Covid-19. There are several aspects of this which may be relevant for the Inquiry.

20. First, managing a government response for a population of three million is significantly different from decision-making for over fifty million. We were conscious of the distinctions between rural and urban areas, between more and less affluent areas and between north and south Wales. However, in the context of the pandemic, the evidence showed us that the key geographic differences were often between east and west Wales. We saw the effect of the virus spreading at different rates across Wales in a series of waves and patterns generally moving from east to west. Our response had to reflect this evidence. The smaller population was not, of itself, a sufficient condition for enabling things to work well,

but it did allow us a greater ability to understand how the pandemic was making an impact (or was about to make an impact) in different communities and to work with local leaders across Wales to make decisions that were sensitive to the needs of different areas.

21. Secondly, the smaller scale (combined with technology) meant that we were able to set up calls with all necessary partnerships, for example, all local authority leaders or all NHS leaders at the same time in a way that would not be possible elsewhere. In the context of this module, it was necessary that those who needed to be tested were able to access a test, whether this was in a city or a rural part of Wales and this was achieved through working in partnership with the NHS in Wales and local authorities.

22. Thirdly, the relative stability of the political structures in Wales meant that we came into the pandemic benefitting from many longstanding personal and institutional relationships which had been built up over many years, where people had worked together on many common agendas and could use that human capital to sustain key relationships. It meant that, when Welsh Ministers started having difficult conversations about challenging decisions, we were often in the position where there was rarely a single person in those conversations whom we did not already know and with whom we had not worked co-operatively on other matters. This commonality of approach applied across political parties. Cross-party co-operation is commonplace in the Senedd and working together across local authorities with differing political leadership is the norm in Wales, not the exception. There are also a number of partnership councils such as the statutory Partnership Council for Wales meant that, from the beginning of devolution, people of different political persuasions representing different interests were around the table together.

23. Before the pandemic the Welsh Government put in place plans to develop and strengthen social partnership, recognising that the established partnership with unions and employers was crucial to the way that we worked as a government. The decision was therefore taken to put social partnership on a statutory footing which was subsequently achieved as part of the Social Partnership and Public Procurement (Wales) Act 2023. A Shadow Social Partnership Council was

established in advance of the legislation to discuss strategic issues relating to fair work and social partnership. Membership was tripartite – consisting of government, unions and employers and chaired by myself as First Minister with other Ministers attending where necessary.

24. The Shadow Social Partnership Council became a very important vehicle during the pandemic. We expanded its membership to approximately 25 senior representatives from across the devolved public services, the private sector, the trade unions and the voluntary sector as well as the different Welsh Commissioners. We also expanded its remit and radically altered its operations; rather than a formal quarterly meeting, it met much more frequently, sometimes weekly, for an hour, and focused on the most difficult decisions in front of us at the time. The Council had direct access to the Welsh Government's key advisers, such as the Chief Medical Officer for Wales, the Chief Scientific Adviser for Health and the Chief Executive of NHS Wales. The Council heard, in advance of publication, about how and why the government was thinking of making decisions. Having listened to their views, decisions were adapted where good reasons for doing so emerged from that deliberation. A chronology of the Shadow Social Partnership Council meetings is provided as exhibit **MD-7/003 - INQ000101236**. As noted from the end of May 2020 regular updates were provided on Test, Trace, Protect. The minutes of the Shadow Social Partnership Council have been provided to the Inquiry.

<u>The effect in the pandemic of a more unified NHS in Wales</u>

25. There are structural differences between the way that the NHS operates in Wales as compared to the NHS elsewhere in the United Kingdom. We have not adopted the market-based NHS system of the Health and Social Care Act 2012, and we did not follow the UK Labour government model of creating NHS Foundation Trusts from 2003. Rather, the NHS Wales seeks to operate as a unified, managed and planned public service.

26. During the pandemic, our NHS structure – which does not see organisations operating in competition with each other – enabled decisions of the NHS Chief Executive to be implemented by the seven health boards in a consistent way. It

was also consistent with the high trust model of government and equality of access as I explained above.

27. By way of example, this unified system facilitated a mutual aid approach to the rollout of the Test, Trace, Protect programme ensuring that where supplies were limited, especially where demand for services across contract tracing was increased, when one region was experiencing particular pressure due to rapid rises in positive cases, there was mutual aid managed across the seven health boards in Wales enabling support.

The critical balance between lives and livelihoods

28. The balance between protecting lives and protecting livelihoods was one of the key considerations that we were juggling throughout the outbreak of Covid-19 in Wales. It was a constant preoccupation. Livelihoods were at stake from the very beginning, and we were very conscious of this. If we restricted movement and required businesses to close, we were taking decisions that directly affected people's ability to earn a living. While the UK Government's furlough scheme meant that thousands of people in third sector organisations and private businesses had a level of income protection, they still had to manage with only 80% of normal incomes. Concurrently, very clear advice was given to the Welsh Government that taking certain action would save lives, without which there would have been avoidable loss of life.

29. In striking that balance, consideration of the needs of the vulnerable and disadvantaged was central to our decision-making and I return to this issue in Part D below.

Collective decision-making

30. During the fast-paced developments in the early stages of the pandemic, I was anxious to find a way of ensuring that all major decisions (for example, in relation to the 21-day reviews of restrictions) were made collectively, involving as many of my Ministerial colleagues as was practicable. It concerned me that colleagues were bound by responsibility for decisions but were potentially not in the room when decisions were made because of shielding arrangements, for example. If we

acted in a way that excluded some from the decision-making process, we would have developed an early and difficult fracture in the collective way that Cabinet operated. After 23 March 2020, we were all working from home. Although this brought challenges, it also created new opportunities. A conscious decision was taken that every meeting from there on should become a virtual meeting of the whole Ministerial team and not just Cabinet members. I continued that until I ceased to hold the office. It mattered a great deal to me that, when we made difficult decisions, not a single Minister felt that they had not had every opportunity to test arguments or voice concerns about the conclusions arrived at. It meant that decisions were subject to the greatest possible scrutiny and that conversations that started with a variety of views coalesced towards a gradual, coherent conclusion that everyone was comfortable in supporting and defending. There were very rare occasions when no consensus emerged and it was necessary for me to act as the first amongst equals. The infrequency of such instances demonstrated, I believe, the strength of our collective decision-making.

31. I was keen for other senior politicians to have independent access to the people advising the Welsh Government. Regularly from 1 April 2020 onwards, we had meetings in which the opposition leaders (Welsh Conservatives and Plaid Cymru) participated, which I chaired. The agenda usually included the following headings for discussion: public health update; NHS update; local government update; contingencies/resilience update; and other emerging issues. The meetings included the Chief Medical Officer for Wales providing an update on the state of the virus in Wales, the Chief Scientific Adviser for Health providing an update on modelling and the Chief Executive of the NHS providing an update on the NHS demand. The opposition leaders could test the information so that they understood the advice upon which our decisions were based. These meetings were not intended to persuade others of the wisdom of the Welsh Government's decision-making. They were, rather, designed to share information and advice in a way which helped those of different political persuasions to come to their own conclusions. Test, Trace, Protect was discussed in several of these meetings, including testing numbers and results, and I exhibit examples the notes of Covid-19 Core Group meetings on 15 April 2020 as **MD-7/004 - INQ000311859,** 29 April 2020 as **MD-7/005 - INQ000311831**, 13 May 2020 as **MD-7/006 - INQ000221186**,

3 June 2020 as **MD-7/007 - INQ000311860,** 10 June 2020 as **MD-7/008 - INQ000314525** and 8 July 2020 as **MD-7/009 - INQ000311825**.

32. It is also important to note that the Senedd continued to meet (virtually, when required) throughout the pandemic, with Ministers available to provide information and answer questions at every stage.

33. The Senedd also had a critically important role in scrutinising the decisions we made during the pandemic. I was determined that we should remain open to the democratic scrutiny of the Senedd, which was the only parliament in the UK to sit throughout the pandemic period. Members of the Senedd were able to scrutinise the actions and decisions of the Welsh Government through:
    a. the regular oral statements I and other Ministers made to the Senedd;
    b. the role of the Senedd in scrutinising and approving changes to the coronavirus regulations;
    c. the work of Senedd scrutiny committees, which produced several reports on the Welsh Government's pandemic response during the specified period;
    d. oral questions to Ministers.

34. I appeared before the Senedd Committee for the Scrutiny of the First Minister on 3 July 2020, 22 October 2020, 11 February 2021, 16 December 2021 and 31 March 2022.

Ministerial decision-making structures

Cabinet

35. Cabinet is the central decision-making body of the Welsh Government. It is a collective forum for Ministers to decide significant issues and to keep colleagues informed of important matters, which are discussed, either because they raise significant issues of policy or because they are of critical importance to the public. As the then First Minister for Wales, I chaired the Welsh Government Cabinet.

36. Under normal circumstances, Cabinet meets once per week during the periods when the Senedd is sitting. After 23 March 2020, as stated above, I decided Cabinet should be a meeting of the whole Ministerial team and not just Cabinet members. In many ways that aided the intensity of contact which was required in navigating the most challenging decisions we faced. The frequency of Cabinet meetings also changed in the early period of the pandemic to enable a prompt and reactive response.

37. Cabinet members and ministers for the period covering the start of the pandemic and up to the end of the fifth Senedd in April 2021 included the following:

    a. First Minister of Wales, Rt Hon Mark Drakeford MS
    b. Counsel General and Brexit Minister, Jeremy Miles MS
    c. Minister for Finance and Trefnydd, Rebecca Evans MS
    d. Minister for Economy and Transport, Ken Skates MS
    e. Minister for Environment, Energy and Rural Affairs, Lesley Griffiths MS
    f. Minister for Housing and Local Government, Julie James MS
    g. Minister for International Relations and the Welsh Language, Eluned Morgan MS
    h. Minister for Health and Social Services, Vaughan Gething MS
    i. Minister for Education Kirsty Williams MS
    j. Deputy Minister for Economy and Transport, Lee Waters MS
    k. Deputy Minister for Health and Social Services, Julie Morgan MS
    l. Deputy Minister for Culture, Sport and Tourism, Dafydd Elis-Thomas
    m. Deputy Minister for Housing and Local Government, Hannah Blythyn MS
    n. Deputy Minister and Chief Whip, Jane Hutt MS.

38. From May 2021 to the end of the relevant period for this module (June 2022), Cabinet members and ministers included the following:

    a. First Minister of Wales, Rt Hon Mark Drakeford MS
    b. Counsel General and Minister for the Constitution, Mick Antoniw MS
    c. Minister for Finance and Local Government, Rebecca Evans MS
    d. Minister for Economy, Vaughan Gething MS
    e. Minister for Rural Affairs and North Wales, and Trefnydd, Lesley Griffiths MS

f. Minister for Social Justice, Jane Hutt MS
g. Minister for Climate Change, Julie James MS
h. Minister for Education and Welsh Language, Jeremy Miles MS
i. Minister for Health and Social Services, Eluned Morgan MS
j. Deputy Minister for Social Partnership, Hannah Blythyn MS
k. Deputy Minister for Arts and Sport, and Chief Whip, Dawn Bowden MS
l. Deputy Minister for Social Services, Julie Morgan MS
m. Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS
n. Deputy Minister for Climate Change, Lee Waters MS

39. I would regard the Cabinet as the 'core decision-makers'. The essential structure of Cabinet and ministerial decision-making did not change. The practicalities of ministerial engagement changed with remote working.

40. Although the full Cabinet led on collective decisions relating to the Welsh Government pandemic response, individual Ministers were required to make decisions in their own portfolio responsibilities, thus underpinning good governance and prompt decision-making. I expected Ministers to exercise portfolio responsibilities themselves save where: (i) a decision required cross-government deliberation and agreement, and (ii) issues emerged of significance that Cabinet consideration was required.

41. During the early stages of the relevant period, if a pandemic-related decision was to be taken by a Minister which required financing, a Ministerial Advice would be submitted to the Star Chamber, a mechanism set up early in the pandemic period to consider financial assistance required in the response to the pandemic, for consideration and once agreed, it would return to the original Minister for approval.

42. Guidance is regularly and routinely provided by the Welsh Government across the whole range of our responsibilities. When this is essentially technical or professional in nature, responsibility for its development and issuance can be delegated to officials. When guidance signals a more significant development of policy or practice then agreement usually rests with the portfolio Minister. Where guidance of that sort cuts across portfolio responsibilities or deals with a matter which engages the wider programme of Government, then it can be reported for

Cabinet discussion and endorsement. In normal circumstances such instances are rare, because changes of this magnitude normally involve actions which go beyond the issuance of guidance. In January and February 2020, such guidance would have remained the responsibility of the portfolio Ministers.

Covid-19 Core group

43. I set up a 'Core Ministerial Group' which consisted of the Ministers most involved in developing the pandemic response and key officials. Initially this comprised of myself, the Minister for Health and Social Services, the Minister for Housing and Local Government and the Minister for Education. This was the core membership, but there was an open invitation to other ministers to attend. From the outset there was an understanding that membership would be reviewed regularly. On 25 March 2020, the Covid-19 Core Group membership was widened to include the Leader of the Welsh Local Government Association and from 1 April 2020 the opposition party leaders of Plaid Cymru and the Welsh Conservatives. The Chief Executive of the Wales Council for Voluntary Action was invited from 8 April 2020 and various external groups (such as the Police, Army and the Black Asian Minority Ethnic Covid-19 Advisory Group) were invited to provide updates from their respective areas as well. The purpose of the group was for information sharing, rather than decision-making. It met weekly between 2 March and 14 September 2020.

Daily ministerial calls

44. From early April, I held regular daily morning calls at 9 a.m. with all Ministers. The purpose of the call was to ensure that the whole ministerial team continued to operate together, sharing information and contributing to the process of decision-making. The fast-moving nature of the crisis, and the many ways in which problems required a response across different portfolios, meant that a daily call, at the start of each day, involving all Ministers proved invaluable in assisting responsive and collaborative decision-making. An email would usually be issued from my office, following the meeting, capturing the issues that had been discussed at the 9am call. I exhibit as **MD-7/010** - **INQ000361519** an example of the email circulated following the call on 20 April 2020 during which we had an opportunity to discuss the testing review that had been conducted and released the previous day.

Meetings with the Health and Social Services Group.

45. From early in the pandemic, the Minister for Health and Social Services and I attended regular meetings with members of the Health and Social Services Group on matters related to the Test, Trace, Protect policy and performance. These meetings were very frequent during the initial response phase, up to several times a week, which reflected the pace of events and complexity of some of the decisions under consideration. These then developed into a weekly meeting, which was later reduced to fortnightly. On occasion, and where relevant, other Ministers would attend, such as when there were discussions regarding testing in schools or elements of the protect aspect of the programme.

Weekly Health Ministers Calls

46. These calls were established early in the pandemic and continued throughout. The purpose of these meetings was specifically to discuss pandemic related issues that sat centrally within the Health and Social Services ministerial portfolio. They were attended by myself, the Minister for Health and Social Services, the Chief Medical Officer and the Director General / Chief Executive NHS Wales.

47. The decisions in respect of the Test, Trace, Protect programme in Wales sat within that ministerial portfolio but as First Minister, I had the overarching responsibility for the formulation, development and presentation of Welsh Government policy. Given the significance of the programme and the scale of the activity generated by it, I took the view that it was not appropriate simply to sub-contract the decision-making to the Minister for Health and Social Services.

48. We would meet every week to consider these matters and, during the latter stages of the pandemic, this reduced to fortnightly. The substantive work carried out between these meetings in relation to the Test, Trace, Protect programme would generally be undertaken by the Minister for Health and Social Services. However, the meetings allowed me to be directly engaged on the latest information and latest policy challenges, along with the decisions to be made.

Ministerial advice

49. Where a decision was for me to make, then I would have received Ministerial Advice addressed to myself, an example of which I exhibit as **MD-7/011 - INQ000145553**. I was routinely copied in on Ministerial Advice sent to the Minister and Deputy Minister for Health and Social Services, whose responsibility it was to make the decision. On such occasions, I would exercise my judgement to decide whether I need to consider the advice or not. From time to time, I would have sent a message to the relevant Minister with my thoughts on the issue. However, detailed questions on the rationale for the decisions taken on these matters were better directed to the Minister for Health and Social Services. Where I had any relevant input in such matters, I have set out those instances within this statement.

Four Nations engagement

50. I have outlined in substantial detail my engagement and interactions with the UK Government and other Devolved Governments in my first and second statements in Module 2, which I exhibit here as **MD-7/012 - INQ000273747** and **MD-7/013 - INQ000280190**, along with my M2B statement, which I have exhibited above. There were engagements at ministerial level and official level across all Welsh Government portfolio areas, although I and other Ministers would not be privy to the full details relating to levels of engagement between officials.

51. The principal platform for four nations discussion was the COBR meetings and calls with the Chancellor of the Duchy of Lancaster, which I have set out in detail in my M2B statement.

52. I would attend these meetings myself or, where the issues being discussed more comfortably sat in the portfolio of another Minister, that Minister would attend. By way of example, the first three COBR meetings in relation to Covid-19 of which I am aware were held on 24 January, 29 January and 5 February 2020, the Minister for Health and Social Services attended on behalf of the Welsh Government because these COBR meetings focused on health-related issues and that was his portfolio. As the situation escalated, I also attended COBR.

53. I also attended the majority of the Chancellor of the Duchy of Lancaster calls and these would consider issues relating to Test, Trace, Protect where appropriate. I have set out further below in the chronology where such issues were dealt with materially.

54. I am also aware that such issues would be discussed in the meetings attended by the respective Ministers for Health and Social Services with their counterparts in the UK and Devolved Governments. Where relevant, information from these meetings would be fed back to me, including at the weekly meetings referenced above.

The Welsh Settlement

55. I am informed that the Welsh Government's corporate statement to the Inquiry in this module has set out the Welsh settlement in respect of powers relating to Test, Trace, Protect and so I do not repeat the same information here.

Part B: System Readiness

56. I understand that in 2008, at the request of the then Welsh Assembly Government, a multi-agency working group was convened to consider pre-existing plans for the investigation and control of communicable disease. The outcome of this work was the publication of the Communicable Disease Outbreak Control Plan for Wales published in March 2011, which was intended as a framework for managing all communicable disease outbreaks with public health implications across Wales and sets out the roles and responsibilities for partners in Wales. The original plan is exhibited as **MD-7/014** - **INQ000128967**. The plan has been updated at various stages, the most recent being in December 2023 and which is exhibited as **MD-7/015** - **INQ000514002** and which is a further consolidation of a single "all disease" plan and where learning from the Covid–19 pandemic response, external review of the Health Protection System and changes to legislation have been considered and reflected.

57. At the start of the pandemic, the NHS in Wales had a network of NHS laboratories – the majority of which were managed by Public Health Wales to deliver pathology testing across the NHS. Cwm Taf Morgannwg and Aneurin Bevan University

Health Boards also managed some of the pathology laboratories. This was not, however, at the scale of nationwide testing capacity.

58. Disease outbreaks were managed by environmental health officers who sat within local authorities in Wales. Local authorities have powers to require, request or take action for the purposes of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents, or could present, significant harm to human health.

59. The system for collecting data on and sharing information on notifiable diseases was determined by the Health Protection (Notification) (Wales) Regulations 2010. These Regulations place obligations on various persons such as registered medical practitioners and operators of diagnostic laboratories to disclose information regarding notifiable diseases to local authorities or other specified bodies with a health protection role (such as Public Health Wales) for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination. These Regulations were amended in 2020 to add 'coronavirus' to the list of notifiable diseases and in 2021 to make provision for notification of Covid-19 test results to Public Health Wales for international travel purposes.

60. The pre-existing infrastructure had responded to earlier outbreaks, for example, during 2019, there had been a tuberculosis outbreak in the Llanelli area. The basic approach of dealing with it was to identify cases, track the contacts of those cases and test them in order to bring the outbreak to an end.

61. Accordingly, and in January 2020, the Welsh health system had had recent experience of running a Test, Trace, Protect-type scheme, albeit on a much smaller scale. Although there was no specific plan for the development of a scalable and rapidly deployable Test, Trace, Protect system at the outset of the pandemic, this way of responding to a public health communicable disease was not a new one. For that reason, when the Chief Medical Officer began discussing this as a technique to deal with Covid-19, it was not an unfamiliar prospect to Ministers or the health system.

62. Although the pre-existing infrastructure had to be expanded quickly and supplemented by the lighthouse laboratory network, which I address further below, the pre-existing infrastructure had served the nation well – this was supported by the characteristics in Wales and the more unified NHS in Wales which I describe above.

Part C: Key Legislative Changes and Chronology of Key Decisions

63. I have set out below the key meetings, decisions and policies introduced in respect of Test, Trace, Protect, along with the relevant key legislative changes introduced in Wales in which I was involved.

Key Public Health and Coronavirus Legislative Changes

64. Section 45C of the Public Health (Control of Disease) Act 1984 ('the 1984 Act') provides a broad power by which the Welsh Ministers can make regulations to prevent, protect against, control or provide a public health response to the incidence or spread of infection or contamination in Wales and England, including where the threat originates outside of Wales and England. This power forms the basis for the public health legislative framework in Wales and, during the relevant period, amendments were made to existing legislation and new legislation made utilising such powers under the 1984 Act, including in relation to the Test, Trace, Protect programme.

The Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020

65. On 26 March 2020, the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 came into force. I was responsible for the making of these Regulations, which sought to impose restrictions on movement by prohibiting all persons from leaving the place where they lived without reasonable excuse, and which imposed a ban on public gatherings of more than two people.

66. The Regulations were reviewed by the Welsh Ministers every 21 days. Although I was responsible for the amendments and replacement (of which there were numerous) of these Regulations throughout the relevant period, significant changes were discussed at Cabinet. Following such discussions, I would be

provided with draft regulations under cover of Ministerial Advice, which I would then formally approve.

67. There are many examples of these discussions outlined in my Module 2B statement exhibited above and, where relevant, I have specifically referenced these in this statement. For example, later iterations of the Regulations imposed the requirement to isolate where a person tested positive for coronavirus or had close contact with such person. The requirement to isolate following close contact with a positive case provided that, upon receiving a notification from a contact tracer of close contact, a person had to isolate for ten days unless an exception applied. The exceptions were set out in the legislation. The Regulations also made it a criminal offence not to comply with the requirements.

The Health Protection (Coronavirus International Travel) (Wales) Regulations 2020

68. These Regulations were made and brought into force on 8 June 2020 and required certain persons arriving at ports from outside of the common travel area (the United Kingdom, the Channel Islands, the Isle of Man and Ireland) to provide information about where they would reside when in Wales and to isolate for 14 days following arrival. Later iterations included provisions on the requirement to isolate on returning from certain high-risk countries and on the requirement for testing to facilitate international travel.

69. As with the domestic regulations detailed above, these were also reviewed regularly to ensure that they remained proportionate to the aims of the Welsh Ministers and the public health justifications. In order for them to be lawful, reasonable and desirable, it was vital that the package of measures was shown to be necessary to prevent danger to public health.

70. Advice on amendments (via the Ministerial Advice process) would usually be submitted to the Minister for Health and Social Services and me. As a result of Senedd procedure, the advice would also be submitted to the Minister for Finance and Trefnydd inviting her to agree to write to the Llywydd (the Presiding Officer in the Senedd) to make her aware that the regulations had been made without

following the usual convention of delaying their coming into force until 21 days after laying them.

71. Following this Ministerial consideration, I was responsible for the making (and amending) of these Regulations. Further detail on my role in the making and amendment of these Regulations and in respect of decisions on testing at the border is set out in Part I below.

Other Relevant Legislation

72. Vaughan Gething MS and Eluned Morgan MS were also engaged in the making and / or amendment of various Regulations during the relevant period in their capacity as the respective Ministers for Health and Social Services. Such Regulations included amendment to the Health Protection (Notification) (Wales) Regulations 2010 and the making of the Health Protection (Coronavirus) (Wales) Regulations 2020. I understand that Vaughan Gething MS has detailed his work in respect of these in his Module 7 statement to the Inquiry.

Chronology of Key Decisions

73. The first three COBR meetings in relation to Covid-19 of which I am aware were held on 24 January, 29 January and 5 February 2020 and were attended by the Minister for Health and Social Services.

74. The first COBR meeting I attended was on 18 February 2020, exhibit **MD-7/016 - INQ000056227** refers.

75. During January and February there was some limited and preliminary evidence which suggested the possibility of asymptomatic spread. While I cannot recall a precise date this would have been when I became aware of asymptomatic infection and the possibility of asymptomatic transmission. The Welsh Government considered asymptomatic transmission but concluded that there was insufficient evidence upon which to base operational decisions (. However, during March and April the knowledge in relation to the risk of asymptomatic spread started to develop, and from the end of April the Welsh Government introduced more stringent testing requirements in relation to discharge from hospital into care homes (although the guidance was also dependent on availability of sufficient

testing capacity). By late April 2020, there continued to be growing knowledge of asymptomatic transmission by the Technical Advisory Cell. The key point I wish to make on asymptomatic transmission is that while in hindsight more could have been done in relation to curtailing the spread of Covid-19 by asymptomatic transmission, there needed to be a sufficiency of evidence before operational decisions could be based on it – that was a matter for the professional judgement of those who provided advice to us. The number of patients being discharged per day was not enormous, and in hindsight the amount of testing that would have been needed may have been accommodated. However, that was not the advice that Ministers received at the time. As the risk became more well understood, operational decisions were adapted accordingly.

76. The first Covid-19 positive case was reported in Wales on 28 February 2020.

77. Cabinet met on 16 March 2020, exhibit **MD-7/017 - INQ000048797** refers. I gave an update on the 12 March COBR meeting where agreement was reached on measures to manage the outbreak, including household isolation. The UK Government had decided to advise against mass gatherings but not ban them. Following advice from medical professionals, routine out-patient proposals and non-urgent surgery had been suspended by the Welsh Government. Cabinet agreed the need for specific, clear Welsh communications, as many people in Wales followed UK-lead media outlets. It was suggested that TV news channels should be encouraged to use sign language. 'Cocooning' was also a term that was being rehearsed and was a measure intended to protect people over 70 years of age and those who were extremely medically vulnerable. Ministers suggested there was a need to consider increased loneliness and the impact on multi-generational households. It was noted that Wales would move to routine testing of key workers only. Advice from health professionals was required to inform the decision on schools – the impact on exams, vulnerable students and those in receipt of free school meals needed to be considered. There was a need to consider the impact on Senedd business, particularly in relation to legislation.

78. At the COBR meeting on 23 March 2020, exhibits **MD-7/018 - INQ000056213** I recall that I raised the issue of vulnerable people because I was aware that the

population of Wales is older, poorer and sicker than the population of the UK as a whole. I was reflecting the nature of the Welsh population and was concerned about how people would access food, medication and would withstand the inevitable loneliness of societal lockdown. I also raised the position of vulnerable children as there were communities in Wales where as many as 80% of the children were in receipt of free school meals. The minutes record that there needed to be joint guidance on how the social distancing guidance would affect vulnerable groups, along with highlighting the position of vulnerable school children who would need to be receiving free school meals. The actions from the meeting record that a discussion of free school meals and vulnerable children in relation to social distancing would be taking place at the Public Sector Ministerial Implementation Group on 24 March 2020 and that the Department for Housing, Communities and Local Government would share guidance on social distancing in supermarkets with the Devolved Governments.

79. On 27 March 2020, I was copied into Ministerial Advice (MA/VG/1136/20) to the Minister for Health and Social Services on the Welsh national testing plan, exhibit **MD-7/019 - INQ000136770** refers and which related to the scaling up of testing, introduction of lateral flow tests and Secure Anonymised Information Linkage Databank analysis of test results.

80. Cabinet met on 30 March 2020, exhibited as **MD-7/020 - INQ000320732**. Letters to the 'shielded' group of people had been issued and discussions on supply arrangements for shielded and vulnerable people were ongoing. Testing capacity was increasing. A number of public sector bodies required additional funding to respond to Covid-19 and that was to be marshalled by the Star Chamber which had been established to deal with the repurposing of government funds and was chaired by Rebecca Evans MS, the then Minister for Finance and Trefnydd.

81. On 7 April 2020 at a meeting with the Minister for Health and Social Services, I outlined seven principles which should be used in the development of options for easing restrictions, one of which was that measures should have a positive equality impact, exhibit **MD-7/021 - INQ000349283** refers. These principles formed the basis of the recovery framework that was published on 24 April (see below). During

this meeting, I was updated by the Minister on the new testing plan and the operation of the new testing centres.

82. The testing plan for Wales was published on 7 April 2020. A copy of which I exhibit as **MD-7/022** - **INQ000083242.** The National Testing Plan had two key objectives, the first was to reduce the harm caused by Covid-19 and the second was to help the public and professionals get back to their normal daily lives.

83. On 8 April 2020, I attended the Covid-19 Core Group, exhibit **MD-7/023** - **INQ000311826** refers. Cases were rising and the spread was east to west and south to north. Progress continued on increasing testing capacity for health and social care workers. The peak was expected in 2 – 3 weeks' time, with a vaccine not expected to be available until the end of the year at the earliest.

84. On 15 April 2020, a ministerial meeting on social care also took place, exhibit **MD-7/024** - **INQ000336415** refers. The meeting discussed the issues in relation to PPE and testing capacity. Care Forum Wales and Care Inspectorate Wales raised concerns about the discharge from hospital to care homes policy and testing. A consolidated list of actions was agreed to address the issues raised, including consideration by the Chief Medical Officer for Wales of testing on discharge from hospital. Following this meeting the Chief Medical Officer for Wales and the Deputy Director General, Health and Social Services advised Public Health Wales of the ministerial discussion and requested a revised approach to testing to be put in place as soon as possible. The outcome of this was the publication of revised Welsh Government guidance on hospital discharge on the 29 April 2020, exhibited as **MD-7/025- INQ000081080.**

85. On 18 April 2020, the Welsh Government published a review of its coronavirus testing regime at which time over twenty thousand tests had been completed, with approximately 40% of these on front line health care workers. A copy of the review is exhibited as **MD-7/026** - **INQ000182403.** The review described a range of issues, including supply chain issues that would preclude achieving the milestone of 5000 tests by the third week in April 2020 but committed to providing weekly updates setting out expected and actual increase in testing capacity.

86. On 22 April 2020, I attended a Covid-19 Core Group meeting, exhibit **MD-7/027 - INQ000311833** refers. The rate of transmission had stabilised which demonstrated measures were working. However, there were high transmission rates in closed settings, such as care homes. There remained concerns about the supply of PPE, testing and the control of the disease in care homes. However, it was noted that testing was being prioritised within health and social care settings. The first priority was patients and patient care, with social care staff being the second priority for testing. Thereafter, testing capacity was to be utilised to help with surveillance of the transmission of the infection, followed by other key workers where evidence suggested there were low levels of transmissibility.

87. On 24 April 2020, I published *Leading Wales out of the Coronavirus pandemic: A Framework for Recovery,* exhibited as **MD-7/028 - INQ000349353**. This document set out the evidence, principles and public health approach that the Welsh Government would apply when considering whether/how to lift restrictions. Firstly, it set out the measures and evidence by which we judged the current infection level and transmission rates in Wales. Testing was central to this pillar. To achieve the increased focus on this, it was confirmed that testing capacity and capability was being stepped up to meet needs in all parts of Wales. Increased population testing was required to determine the infection rate was decreasing. Secondly, it set out seven principles that we would use to examine proposed measures to ease the current restrictions, taking into account scientific evidence, wider social and economic impacts, and whether a measure had a positive equality impact.

88. Thirdly, it set out how we would enhance our public health surveillance and response system to enable us closely to track the virus as restrictions were eased. It would be based on consideration of four harms: direct harm to individuals from Covid-19; harm flowing from the NHS becoming overwhelmed; harms from non-Covid-19 illness through lack of diagnosis and treatment of other conditions; and socioeconomic and other societal harms. This response required four strands: improved surveillance; effective case identification and contact tracing; learning from international experience; and engaging with the public.

89. Insofar as improved surveillance was concerned, the Framework indicated the intention to monitor transmission particularly in communities, in vulnerable groups and in NHS care settings. That surveillance was to be supported by strand two, which confirmed a significantly scaled, digitally supported, co-ordinated and locally implemented contact tracing operation across Wales. Co-ordination during the recovery phase was confirmed to be undertaken by Public Health Wales and locally implemented under the leadership of local Directors of Public Health. It was acknowledged that this would require a significant upscaling of a much wider public health workforce drawing on existing health protection and environmental health staff, community health staff, the voluntary sector and community groups, with Public Health Wales developing a standard operating framework to support this.

90. On 29 April 2020, I attended the Covid-19 Core Group meeting, the minutes of which are exhibited as **MD-7/005 - INQ000311831**. The Chief Medical Officer for Wales reported that the transmission rate had reduced significantly which demonstrated that the lockdown measures were effective. The main focus was on testing health and social care staff and preparing for the lifting of lockdown, with Public Health Wales in the process of developing a draft plan. Councillor Andrew Morgan confirmed that local government was engaged with the plans for lifting the restrictions.

91. The efforts were also being supported by military officers who were sharing their expertise on professional planning and other ranks were being deployed in several frontline areas including assisting in the establishment of testing centres, and the Core Group received an update from senior officers during the meeting on 29 April 2020. For example, a team had been embedded within Public Health Wales to help design and roll-out testing facilities in Llandudno. It was recognised that facilities would need to be sufficiently flexible to cover the whole of North Wales and support those who could not travel, such as care home residents. Once established, it was intended that similar systems would then be deployed across rural areas of Wales.

92. The military was also working with Deloitte on testing facilities that were already in place and was providing transportation to help non-drivers visit the testing centres, along with support to train individuals to undertake the tests. At this stage, it was

noted that test results were being delivered to patients within two days, but the aim was to reduce this to under 24 hours. I formally thanked the military at this meeting for all the support that had been provided to civilian services across Wales in responding to the pandemic.

93. On 30 April 2020, Ministerial Advice (MA/VG/1461) was sent to the Minister for Health and Social Services relating to the Covid-19 testing strategy and the care sector, exhibit **MD-7/029** - **INQ000353847** refers. The Ministerial Advice set out that that although community transmission was reducing, there was a large number of cases and outbreaks in the care sector. As noted above in paragraph 84, there were concerns about care homes at the start of April 2020 and a ministerial discussion had taken place on 15 April 2020 resulting in a request from ministers for further advice and revision of the guidance on hospital discharge into care homes. By this point, it was generally accepted that individuals may be infectious for up to two days prior to the onset of symptoms and Public Health Wales agreed that testing of asymptomatic care workers would help to prevent infections in care homes. However, expanding testing to asymptomatic residents still lacked an evidence base to support the best use of testing capacity. Although the decision was that of the Minister for Health and Social Services, I considered the advice and on 1 May 2020 my private office confirmed, by email, that I was fine with the advice and had noted that the Minister for Health and Social Services had cleared it, exhibit **MD-7/030** - **INQ000531693** refers. I understand that this issue is likely to be the subject of further consideration by the Inquiry in Module 6.

94. On 6 May 2020, I attended the Covid-19 Core Group meeting, exhibit **MD-7/031** - **INQ000336509** refers. The Welsh Government decision to test all residents in care homes where an outbreak had been identified was discussed and it was reported that the science had become clearer as to the spread of the virus in closed settings. Testing was also available in larger care homes because they were at greater risk of experiencing an outbreak because of their size and footfall. Officials were working with Public Health Wales on the development of an effective Test, Trace, Protect programme to be introduced when the restrictions were lifted. Strategic Co-ordinating Groups were to have a role with the introduction of these measures. It was confirmed that officials would arrange a meeting between the

Minister for Health and Social Services, the Welsh Local Government Association and Public Health Wales to discuss further the forthcoming Test, Trace, Protect programme.

95. On 9 May 2020, advice was submitted to the Minister for Health and Social Services on the emerging model of Testing and Contact Tracing (MA-VG-1559-20), exhibit **MD-7/032 - INQ000144885** refers. The paper was intended to give an overview of the then-current thinking on the testing and contact tracing programme. There was a plan to issue guidance to local authorities and local health boards during the week commencing 11 May, and to issue a public-facing document setting out the Welsh Government's approach in broad terms. The advice sought comments and feedback on the emerging model.

96. The advice confirmed that, following receipt of Public Health Wales' response plan and discussions by officials with other UK nations, a UK-wide model for testing and contact tracing was emerging, although there remained some unknowns and the potential for there to be some divergence on issues such as whether all four nations would become part of the same telephony service. At that time, the Technical Advisory Cell was working on providing advice on the trajectory for contact tracing. Signposts were provided for future decisions likely to be required to render the programme operational, such as timing for commencement, testing and the most appropriate way to secure engagement by the public.

97. Local authorities and local health boards had embraced their role in contact tracking with pace and purpose, and it was advised that operational plans for contact tracing were being developed on a local health board footprint. Capacity to start contact tracing in some areas was indicated as early as 18 May 2020, with others aiming for 31 May 2020. The engagement with local authorities and local health boards was led by the Test, Trace, Protect team via the Test, Trace, Protect Oversight Group.

98. I received a copy of this advice, noted the same and provided my views for consideration on 11 May 2020, as exhibited at **MD-7/033 - INQ000336535.** My views at the time included my concern that Public Health Wales was not set up to operate as a delivery organisation. Thus, although they were identified in the

advice as to be responsible for establishing, implementing and operating the programme, my view was that the implementation and operation should lie with a tripartite structure involving Public Health Wales, local authorities and local health boards.

99. Other views I expressed included the alerting of contacts at the time of presentation of symptoms rather than upon on results (although this was subject to us having the ability to provide results within 24 hours), the need to be realistic as to the target dates for reaching particular volumes of testing and numbers of staff, and the need rapidly to resolve the issues relating to digital solutions and telephony arrangements, together with establishing a public narrative to explain our actions.

100. On 13 May 2020, I attended a Covid-19 Core Group meeting, a record of which is exhibited at paragraph 25 above. Infection rates remained stable. Death rates in care homes were reducing and it was recognised that the testing of patients on discharge to care homes may have helped with this. It was confirmed that the Minister for Health and Social Services was to announce the Test, Trace, Protect strategy that afternoon in the Senedd. The Strategic Co-ordinating Groups reported that they were preparing for their role in the Test, Trace, Protect strategy.

101. This strategy was published by the Minister for Health and Social Services later that day and is exhibited at **MD-7/034 - INQ000147253**. The strategy was developed to enhance health surveillance in the community, undertake effective and extensive contact tracing, and support people to self-isolate where required to do so.

102. On 15 May 2020, I published *Unlocking our society and economy: continuing the conversation,* exhibit **MD-7/035 - INQ000349373** refers. The document included a traffic light guide for moving out of lockdown and highlighted the lengthy journey still ahead in dealing with Covid-19. Until there was a vaccine or effective treatments, we were going to have to live with Covid-19 and ensure we had measures to limit as far as possible the number of infections and deaths, while allowing our society and economy to function. It was expressly recognised that putting in place an effective system to track, trace and protect was essential to

continue moving out of lockdown, in order to identify and isolate new outbreaks and alert those who might have been infected to stay home until they had been tested.

103. On 27 May 2020, Cabinet met, exhibit **MD-7/036 - INQ000221014** refers. The focus of the meeting was the next 21-day review, draft advice and associated documents had been circulated. It was recognised that a critical factor leading to easements in education and childcare at that stage was the need for an effective Test, Trace, Protect system, which was hoped to be possible by the next review period.

104. On 1 June 2020, the Test, Trace, Protect programme was launched in Wales. Part F of this statement below deals with the substantive nature of the programme.

105. The next 21-day review took place in Cabinet on 17 June 2020, exhibit **MD-7/037 - INQ000048799** refers. The paper for the review at exhibit **MD-7/038 - INQ000227453** identified that there was further headroom to introduce new easements, with the monitoring of the situation in Wales having been strengthened by several factors including the implementation of Test, Trace, Protect. It was at this stage too early to deem Test, Trace, Protect effective which is why it was part of a wider surveillance system that included Test Trace and Protect, the work of the Joint Biosecurity Centre, the ZOE 'app' and the monitoring of waste water developed by Bangor University. However, once the system had been in place for a sufficient period of time the Technical Advisory Group evaluated the impact of the Test, Trace, Protect system in reducing the effective reproduction number. I understand that Dr. Robert Orford, the Chief Scientific Adviser for Health and Chair of the Technical Advisory Group during this period has provided a statement to the Inquiry detailing the work of the Technical Advisory Group and provided copies of the reports setting out the evaluation of Test, Trace, Protect in Wales.

106. The essential nature of the Test, Trace, Protect programme for responding to any flare-ups was discussed during a call I attended on 23 June 2020 with the Chancellor of the Duchy of Lancaster, the First Minister of Scotland and the Deputy

First Minister of Northern Ireland, (I shall refer to these calls as 'CDL calls'). A note of this call is exhibited at **MD-7/039** - **INQ000216523**.

107. The next 21-day review took place at Cabinet on 7 July 2020, exhibit **MD-7/040** - **INQ000048852** refers. During review of the relevant restrictions, it was noted that Test, Trace, Protect was in place and had been used to bring under control two outbreaks in North Wales and an incident in Merthyr Tydfil. The success of the programme in this regard had also been shared by me to the other nations on a CDL call the previous day, exhibit **MD-7/041** - **INQ000216524** refers.

108. On 14 July 2020, Ministerial Advice (MA/VG/2299/20) was submitted to the Minister for Health and Social Services and I, which is exhibited as **MD-7/042** - **INQ000336847**. This advice related to the release of an updated Covid-19 Testing Strategy, which had been developed to cover the next phase of responding to the pandemic. The strategy had been developed with input from Public Health Wales and local health boards, the Testing Sub-group of the Technical Advisory Group and in discussion with relevant Welsh Government policy teams; it set out four priorities for testing. These were:

a. Controlling and preventing transmission of the virus by supporting contact tracing;
b. Protecting NHS services to prevent, protect and deliver testing to support the safety of staff, patients and clients;
c. Protecting vulnerable groups and managing increased transmission rates to safeguard and control infection in groups, communities or settings with greater risks;
d. Developing future delivery to utilise health surveillance and new technologies to improve our understanding of the virus and innovate new ways to test.

109. It was noted that the use of asymptomatic testing had implications for testing capacity. Officials were working on modelling to ensure that the needs of contact tracing and asymptomatic testing across outbreaks and in closed settings could be met. It was further noted that demand for tests across the system would

need to be carefully managed and capacity balanced between the Public Health Wales laboratories and the UK lighthouse laboratories.

110. The updated strategy provided, in line with Technical Advisory Cell advice, that PCR testing was not designed for the routine screening of asymptomatic people and was not recommended for use at low prevalence rates. It set out the conditions that would give rise to asymptomatic testing which included: for use in outbreaks, health and care settings; and on the basis of risk analysis undertaken by local health boards with high contact workplaces and vulnerable groups.

111. Local health boards were placed at the centre of planning for testing, with the capacity to respond to mass population symptomatic testing, and responsibilities for responding to outbreaks, targeting asymptomatic testing on a risk basis, recommencing NHS services and protecting the vulnerable. Officials were in a position to follow up with each local health board on developing their testing plans, including to manage any matters associated with regional variations in approach.

112. On 15 July 2020, both the Minister for Health and Social Services and I agreed to the publication of the new testing strategy, exhibit **MD-7/043** - **INQ000368167** refers, and the updated Covid-19 Testing Strategy was accordingly published later that day, which I exhibit as **MD-7/044** - **INQ000300110**.

113. The next 21-day review took place in Cabinet on 28 July 2020, exhibit **MD-7/045** - **INQ000048857** refers. The Chief Medical Officer for Wales advised that the Joint Biosecurity Centre had received data from Wales and confirmed that the situation was favourable and restrictions could continue to be eased. A Technical Advisory Cell report, that was due to be published later that day, had identified a need for action on testing turnaround times.

114. On 6 Aug 2020, advice under MA/VG/2582/20 was submitted to the Minister for Health and Social Services and copied to me, exhibit **MD-7/046** - **INQ000235940** refers. This advice set out the options for enhancing testing

capacity and turnaround times. As at that date, testing was being undertaken by the UK lighthouse laboratories and Public Health Wales laboratories. SAGE had advised that test results should be turned around within 24 hours for contact tracing to be effective. Although they could do so for short periods in response to specific outbreaks, Public Health Wales laboratories were not configured to deliver those turnaround times on a sustained basis.

115. Public Health Wales had provided a clear and realistic plan as to how, with Welsh Government investment in enhanced laboratory capacity, it could progress to achieve those turnaround times, albeit the plan was subject to risks relating to procurement timescales and workforce availability. The Minister for Health and Social Services was asked to agree funding to improve Public Health Wales' laboratory capacity and turnaround times in line with the proposal submitted. Such funding would then permit officials to continue to work with Public Health Wales to ensure delivery and explore all opportunities to implement swiftly. I am aware that the advice was accepted and further funding agreed by the Minister.

116. On 18 August 2020, the Minister for Health and Social Services and I launched the Welsh Government's '*Coronavirus Control Plan for Wales*', which I exhibit at **MD-7/047 - INQ000349794**. This set out the existing systems designed to prevent the spread of the virus as well as new systems that had been put in place to respond swiftly to new cases at a local level. The role of effective health surveillance via testing, tracing and self-isolation in attempting to contain outbreaks at source was recognised as the most likely way to avoid a return to the strictest restrictions. There was a well-established system for bringing together all relevant local agencies through Incident Management Teams and Outbreak Control Teams, which had allowed us to build our Test, Trace, Protect capability and this system was identified as being the cornerstone of the response to local incidents and outbreaks.

117. The Plan framework was based upon three pillars, the third of which was the enhancement of the public health surveillance and response system in several ways, including improved monitoring and effective case identification and contact tracing. The intention behind this approach was to seek to avoid the need for

further far-reaching restrictions by moving to an approach based on prevention and targeted intervention, with the crucial role of testing and monitoring to underpin surveillance being clear. As expressly confirmed in the Plan, the Test, Trace, Protect strategy was a critical part of the response at this time.

118. The situation in Wales had taken a turn for the worse by the time of the 21-day review that took place in Cabinet on 8 September 2020, exhibit **MD-7/048 - INQ000048867** refers. The Chief Medical Officer for Wales expressed concern about the alarming increase in cases in Wales and across the UK, with the resurgence expected in the autumn arriving earlier than anticipated. Testing had identified that there was a particular local authority which accounted for a third of infections and it was placed into a local lockdown in accordance with the principles set out in the Coronavirus Control Plan.

119. On 15 September 2020, the ministerial call received an update from the Minister for Health and Social Services in relation to testing and local lockdowns, exhibit **MD-7/049 - INQ000349865** refers. He stated that lighthouse laboratories were experiencing capacity issues with testing, because the UK Government had made a decision to cut back testing based on England-only data. This had resulted in a disproportionate impact on Wales and Scotland. The Minister for Health and Social Services confirmed that he had spoken with the Secretary of State for Health who acknowledged the issue and confirmed work was ongoing to overcome it. However, the laboratories were not expected to be running at full capacity for another three weeks which posed challenges for the Welsh Government in the interim, particularly as the new university year was starting. Mobile testing was being repurposed to help where this was possible. Calls for a meeting to discuss the issue of testing further with the Chancellor of the Duchy of Lancaster had not proven possible. Both the Minister for Health and Social Services and I had also called for COBR meetings to be restarted in the circumstances of the rise in cases across the UK.

120. At a CDL call on 19 September 2020, the UK Government confirmed its plans to provide financial support to those mandated to self-isolate and that this

would result in Barnett consequential funding to the Welsh Government. I shall return to this meeting in Part H of this statement below.

121. The situation in Wales continued to deteriorate and Cabinet was told on 21 September 2020, exhibit **MD-7/050 - INQ000129855** refers, that four local authority areas had now been placed into local lockdowns. Local authority leaders were already taking action to move staff away from their normal duties in order to respond to the demand for extra capacity within the Test, Trace, Protect system. These were staff who had previously been trained to administer the Test, Trace, Protect programme but had not been deployed to work on Test, Trace, Protect until this time. It was acknowledged by Cabinet that this could lead to the closure of some libraries and other community facilities. I also updated Cabinet as to the outcome of my recent discussions with the Chancellor of the Duchy of Lancaster, as referenced above.

122. In light of the worsening situation across the UK, there had been a response to the calls for four nations engagement and I had spoken with the Prime Minster on 21 September and attended COBR on 22 September, exhibit **MD-7/051 - INQ000083849** refers. At this stage, the four Chief Medical Officers of the UK had agreed that the whole of the UK should move to alert level 4 and there was agreement between the four nations as to the measures to be introduced.

123. Baroness Dido Harding, the Head of NHS England Test and Trace provided an update in the meeting confirming that turnaround times for testing had extended recently, although the vast majority of people received their result within 48 hours, and 64.7% of in-person tests received their results the day after the test was taken. Discussion then turned to priorities for testing, with the UK Government priority being acute critical care followed by social care, which was receiving 100,000 tests a day. The next priority would then be other NHS workers, then other key workers, in particular teachers. Demand for testing had peaked the previous Tuesday, which had likely been driven by schools returning.

124. A recent survey had indicated that approximately 25% of people were booking a test without any symptoms or having been asked to get a test. The

system had also been recently changed to ensure that people would not be sent more than 75 miles for a test. We were updated that the programme was on track to double capacity in pillar 1 and pillar 2 by the end of October and the UK Government had committed £500 million to trialling new technology. However, there was evidence to suggest that the public was not consistently fulfilling the duty to self-isolate.

125. On 25 September 2020, I was copied into advice provided to the Minister for Health and Social Services under MA/VG/3191/20, exhibit **MD-7/052** - **INQ000116654** refers. This advice followed the UK Government's consideration of measures to manage increasing capacity demands. In light of capacity constraints and rising infection rates amongst the public, it was considered necessary to establish a prioritisation list for access to testing. Officials proposed a priority list of six cohorts for Wales which was based upon an assessment of prioritisation carried out by the Chief Medical Officers of the four nations, and was as follows:

a. Priority one, to support NHS clinical care;
b. Priority two, to protect those in care homes;
c. Priority three, to test NHS staff, including GPs and pharmacists where possible;
d. Priority four, targeted testing to support management of outbreaks and surveillance studies;
e. Priority five, testing for school staff with symptoms where needed, to keep schools and settings open (although this was later amended to include all education and childcare staff before publication);
f. Priority six, testing all symptomatic individuals, irrespective of local prevalence.

126. The advice noted that the final priority sector differed from that of the UK Government where it had split the category into two: firstly, testing the general public where they had symptoms in high positivity areas and, secondly, testing the general public where they had symptoms regardless of where they lived. However, this was not recommended for Wales as it could have led to missing evidence of

emerging risk. However, it was confirmed that the consideration of further prioritisation within priority six remained ongoing as the booking technology developed. I am aware that the Minister accepted the recommendations in this advice, agreeing to the prioritisation list for testing and publicly announcing the prioritisation of the National Testing Programme on 29 September 2020, a copy of which is attached as **MD-7/053** - **INQ000395828**.

127. On 21 October 2020, as confirmed in Ministerial Advice (MA/VG/3703/20) that I reference below, the Minister for Health and Social Services and I were briefed by officials with regard to the new technology developments under the UK Mass Testing Programme and field validation of the Lumira DZ point of care devices that had been procured, subject to successful validation, directly for Wales.

128. A fire break was implemented in Wales between 23 October and 9 November 2020 as set out in The Health Protection (Coronavirus Restrictions) (No. 3) (Wales) Regulations 2020 which I made on 21 October 2021.

129. On 30 October 2020, I was provided with a briefing paper that outlined next steps for Test, Trace, Protect and, in particular, how it could be used when the firebreak came to an end, exhibit **MD-7/054** - **INQ000349967** refers. By this time, Test, Trace, Protect had nearly five months of operational experience, with the prior two months at a very significant scale. Significant strengths in the programme were recognised, including:

a. The local / regional model and strength of partnership working had enabled common purpose and integration with wider local / regional structures;
b. The commitment of the contact tracing teams who felt they were playing a role in protecting their communities had been exemplary;
c. The challenges of a hybrid testing approach had resulted in resilience and agility to respond to situations that would otherwise not have developed;
d. The testing infrastructure was accessible and being used in increasingly dynamic ways to target areas of concern;

e. Contact tracing had maintained very high levels of performance in the face of escalating numbers, which had been testament to the dynamic recruiting model used by local authorities.

130. There had also been significant learning regarding the transmission of Covid-19, many features of which made Test, Trace, Protect as a tool to control chains of transmission very challenging. This included the highly contagious nature of the virus, early transmission often before the appearance of symptoms and a proportion of cases being asymptomatic or having mild / variable symptoms, which could lead to individuals spreading the virus unknowingly.

131. This meant that, to gain the maximum benefit from the system, Test, Trace, Protect needed to be fast and, ideally, have turnaround times within 48 hours from test taken to contacts isolated. It was noted that this speed was not being achieved on a consistent basis. It was also recognised that the role of Test, Trace, Protect varied according to the extent of community transmission: when case numbers were lower and there were fewer contacts, it could be a key tool which was highly effective in bringing outbreaks under control, but when social contact was high, case numbers mean that it could not contain transmission alone and a more risk-based approach alongside other non-pharmaceutical interventions was required.

132. Officials had provided a detailed action plan within the briefing which sought to focus on improving accessibility, communications and engagement, along with carrying out further operational improvements, research and resourcing in order to improve the effectiveness of Test, Trace, Protect.

133. On 2 November 2020, I was copied into advice submitted to the Minister for Health and Social Services (MA/VG/3703/20), which is exhibited at **MD-7/055 - INQ000337247**, **MD-7/056 - INQ000361634** and **MD-7/057 - INQ000337248.** This sought to provide an update on developments in new technology following the briefing on 21 October, to agree the approach for Wales on pilot developments and to agree a Written Statement to be published on developments. Following work undertaken by officials, it was noted that new testing technology could provide an opportunity to engage differently with the population to increase the

overall benefits of testing and permit testing at a far greater scale, frequency and speed, along with improved accessibility and lower cost.

134. The new technology developments were classified under three key themes:

a. Lab-based technology / LAMP – this involved increasing capacity and utilising LAMP technology, which permitted detection of the virus more swiftly and portably than a PCR test, albeit not quite as accurately. Wales had also been allocated an Ecolog fully staffed and operational semi-permanent laboratory within a container that could process up to 10,000 tests per day.
b. Point of Care – these point of care devices were undertaking validation but, subject thereto, utilised technology in a small shoe box size machine that could be processed quickly and close to the patient, within 12 minutes up to 30 times per day.
c. Lateral Flow Devices – at this stage, it was noted that these were less accurate than PCR but offered point of care results in less than an hour and so presented the opportunity to run mass testing and surveillance on at risk groups with swift results. The UK Mass Testing Programme was running field trials to determine the rates of false results as compared to PCR tests. At this time, lateral flow device test usage was not clinically recommended without confirmatory PCR testing for any positive result, which had the potential to place further demand pressures on the PCR testing regime.

135. A prioritised approach to engagement with the UK Government on new technology pilots for asymptomatic testing was recommended, with active engagement to have early pilots take place in Wales for high priority areas where it would be useful for system learning. It was confirmed that officials would continue to engage in other high priority areas to seek further information from the UK Government and start discussions with stakeholders as to their benefits where appropriate.

136. I provided my views upon the contents of this advice, and wished to emphasise that, although less accurate than PCR testing, lateral flow device test s could offer point of care results in less than an hour, which raised the opportunity to run regular mass testing and surveillance with specific groups with swift results. Provided those tests could be brought forward successfully, officials were asked to work with the care home sector to consider ways in which the tests could be deployed to support visits by family and friends. I exhibit my response to the advice at **MD-7/058** - **INQ000531746** I understand that the Minister for Health and Social Services accepted the recommendation and the Written Statement in its amended form to reflect the views I had expressed.

137. At the CDL call on 11 November 2020, discussions turned to mass testing. It was confirmed that the evaluation of lateral flow tests from the Liverpool mass testing pilot was encouraging (sensitivity at 70% and specificity at 99%), with the potential for a 50% reduction in transmission by asymptomatic individuals. Challenges remained as to how to incentivise participation and the implications of getting a negative test. As to the wider rollout, this remained in the discovery phase on the role of mass testing in the wider strategy and the potential levers available for participation. Following this update, I congratulated those involved in the progress on lateral flow testing and indicated a need to understand the interplay of this with mass vaccination. I noted that the potential benefits included care home visiting, reducing school absences, potential to allow people to come out of self-isolation and to permit participation in sporting or arts events.

138. In terms of the wider rollout, the Chancellor of the Duchy of Lancaster confirmed that there would be equitable distribution of devices and logistical support on a Barnett basis and it would thereafter be for each government to determine how to prioritise these. He agreed that there would need to be a fair and visible process for rollout and that there needed to be a sense of reciprocity with citizens, and a shared understanding of the purpose and benefits. A note of this meeting is exhibited at **MD-7/059** - **INQ000216557**.

139. On 16 November 2020, I was copied into advice MA/VG/3887/20 to the Minister for Health and Social Services, exhibit **MD-7/060** - **INQ000136827** refers.

The purpose of this advice was to seek agreement to draw down the initial allocations of the lateral flow devices for Wales under the UK Mass Testing Programme. The briefing also asked the Minister to note and agree the first batch of Point of Care devices, which had been validated nationally and which were ready to be drawn down for local operational validation in Wales in preparation for deployment. I understand the Minister for Health and Social Services agreed to the recommendations in this advice.

140. At the CDL call on 18 November 2020, the intention for Barnett shares of devices with the discretion on prioritisation to be a devolved matter was reiterated. Exhibit **MD-7/061** - **INQ000256881** refers.

141. On 19 November 2020, it was confirmed in Cabinet, exhibit **MD-7/062** - **INQ000129889** refers, that Wales would receive a Barnett share of the lateral flow devices, which would amount to around 90,000 being available each day. It was noted that there would be a number of logistical issues to resolve, with current plans being to pilot these tests within care homes. Ministers noted that mass testing would begin in Merthyr Tydfil later that week and it was recognised that it would be important to try and encourage as many people as possible to take up the offer. It was agreed that the Minister for Health and Social Services, the Minister for Housing and Local Government, the Minister for Education and I would need to meet urgently to discuss lateral flow testing in secondary schools and the implications of contacting parents and guardians during Christmas holidays of children who would be required to self-isolate.

142. That ministerial meeting took place later that day and a record of the key points emerging from the meeting are set out in **MD-7/063** – **INQ000530833.**

143. Cabinet met on 26, 27 and 29 of November 2020 to discuss Winter planning, exhibits **MD-7/064** - **INQ000048925**, **MD-7/065** - **INQ000048927** and **MD-7/066** - **INQ000048930** refer. As may be seen from the minutes and the recommendations paper exhibited at **MD-7/067** - **INQ000048997**, consideration of data provided by Test, Trace, Protect, was one type of evidence considered by Ministers in determining the appropriate interventions to put in place over the

forthcoming period. That evidence pointed towards the virus being transmitted predominantly in household settings, hospitality and through workplaces and it was suggested that measures to mitigate transmission in these settings could reduce the impact pre-Christmas. As outlined in my statement to the Inquiry for Module 2B, we considered many different sources of evidence and papers in making these decisions.

144. At the CDL call on 2 December 2020, all four nations updated on the progress of mass testing in their countries. Exhibit **MD-7/068** - **INQ000216559** refers.

145. On 4 December 2020, I was copied into Ministerial Advice (MA/VG/3918/20) submitted to the Minister for Health and Social Services for decision. This advice sought the Minister's agreement to the roll out of the LumiraDX devices throughout Wales to deliver the Welsh National Covid-19 testing strategy and priorities and to permit an increase in diagnostic capacity. A copy of this advice is exhibited at **MD-7/069** - **INQ000361643**. I am aware that the Minister agreed to the recommendation to proceed with Phase 1 which involved the drawdown of 100 LumiraDX devices and 100,000 test strips before the end of December 2020 to distribute to health boards, focusing deployment on testing symptomatic patients initially in emergency departments and within primary care settings in line with agreed clinical pathways, and thereafter to draw down the remaining 300 devices early in the new year for agreed pathways for testing symptomatic and asymptomatic individuals.

146. On that same date, I was also copied into a further advice (MA/VG/3946/20) for the Minister of Health and Social Services, exhibited at **MD-7/070** - **INQ000235872**. The Ministerial Advice confirmed that the Welsh Government and Tata Steel had been approached by the Department of Health and Social Care to ascertain interest in rolling out a pilot project associated with mass testing in private industries and this would involve the use of lateral flow devices at the TATA Steel site in Port Talbot, with a view of learning from this pilot and the potential to roll out similar screening programmes in the near future. A soft launch had occurred that week with a view to going live from 6 December.

147. An updated Coronavirus Control Plan was published on 14 December 2020, exhibited as **MD-7/071 - INQ000227576**. In the foreword, both myself and the then Minister for Health and Social Services recognised that the approval of the first Covid-19 vaccine earlier that month, and the promise of more to come, coupled with the start of our vaccination programme in the last week, had been a genuine breakthrough in the pandemic which brought with it promise of a brighter future in 2021. The Control Plan acknowledged that the process of vaccinating everyone would take time; it would be a while before the benefits of the vaccination programme were seen and the roll out needed to continue in tandem with other restrictions.

148. Our testing strategy continued to be an important part of the Plan, with people advised to isolate immediately and test upon appearance of symptoms of Covid-19, meaning a recent onset of a new continuous cough and/or high temperature. As the pandemic progressed, and our understanding of variants developed, a wider range of symptoms were recognised. It is difficult to say in hindsight whether the wider range of possible symptoms should have been better communicated to the public. Advice on the symptoms to trigger isolation and testing was taken from the UK Chief Medical Officers and remained linked to the key main symptoms. As noted above, a recent survey had indicated that approximately 25% of people were booking a test without any symptoms or having been asked to get a test. The impact of using a wider range of symptoms is very difficult to assess. In hindsight this may have resulted in unnecessary testing and adversely impacted the test capacity available or may have reduced transmission. I am not able to say with confidence what the impact would be and therefore unable to comment on whether more should have been done to communicate a wider range of symptoms to the public. The Plan did however advise that it was a legal requirement in Wales to self-isolate if advised by the Test, Trace, Protect service and that new testing technology, including rapid-result tests to help identify coronavirus in people without symptoms, was being rolled out in Wales. It was hoped that these would assist (i) in identifying infections at an earlier phase, before the onset of symptoms, thereby reducing the risk of onward transmission, and (ii) in limiting the impact of self-isolation on people who were identified as contacts of

a positive case, potentially helping to reduce the economic and social harms that could arise.

149. At the CDL call on 17 December 2020, I updated the other governments regarding recent media reports of 11,000 allegedly missing test results in Wales. These were inaccurate: Public Health Wales had announced the previous week that it was conducting maintenance on its systems and there would be an impact on when test results would be reported. A note of this meeting is exhibited at **MD-7/072 - INQ000256887**.

150. I announced that Wales would enter into Tier 4 restrictions on the 20 December 2020, this was sent out in the Health Protection (Coronavirus Restrictions) (No. 5) (Wales) (Amendment) Regulations 2020 which I made the previous day and I issued a statement to confirm the restrictions which is exhibited as **MD-7/073 - INQ000350125** .

151. On 30 December 2020, the Oxford-AstraZeneca vaccine was approved for use in Wales and across the UK. The key context for decisions of the Welsh Government altered with the arrival of an effective vaccine. From that point onwards, so much of our policy effort, practical action and communication with the Welsh public revolved around making the best possible use of the opportunity provided by vaccination.

152. As we emerged into the New Year of 2021, the position in Wales remained perilous. Vaccination was already taking place, but numbers remained at the foothills of the long journey of rolling out its advantages to as many people as possible. At this stage, non-pharmaceutical interventions remained central to our purpose of protecting people in Wales from the impact of a deadly virus.

153. In the early part of 2021, the Welsh Government approached the lifting of protections by drawing on what we regarded as the strengths of our approach so far. We used the reliability and predictability of the 21-day cycle as the bedrock of our decision-making. We reaffirmed our approach of graduated and proportionate change restrictions, calibrated against the changing prevalence of the disease over

time. We continued to draw on the advice of the Shadow Social Partnership Council and all the discussions which lay behind it, as an important way of involving partners in the decision-making process. We also continued to communicate the practical changes to people in Wales by sharing with them the information available to us as a government, and the rationale for the decisions we made.

154. At a CDL call on 13 January 2021, exhibit **MD-7/074** - **INQ000495959** refers, I asked about the impact of mass testing in Liverpool and the Chancellor of the Duchy of Lancaster undertook to share the analysis. I offered to share our paper on the whole town testing that had taken place in Merthyr in response.

155. Testing was further discussed during the CDL call on 20 January 2021, a note of which is exhibited at **MD-7/075** - **INQ000216570**. It was recognised that the emergence of the vaccine would not remove the need for testing and this would be required for many months. On that basis, the UK Government confirmed that it was investing substantially in its mass testing infrastructure. It reported having learned a number of lessons from its mass testing pilot: targeting and flexibility was essential, there was a need to support local authorities to overcome barriers and there were challenges for the UK Government and local authorities to ensure there was a joined-up approach to the plethora of offers.

156. I indicated my gratitude for the update and that I considered the key challenge was that, while we were learning many lessons about delivery, we did not yet know what the return was on the intensive investment in mass testing. The experience in Liverpool had made people sceptical of the impact of mass testing. I confirmed that, in Wales, we were likely to focus on a highly targeted approach in future. Clarification on the population shares of the lateral flow devices was sought by the First Minister of Scotland and the Chancellor of the Duchy of Lancaster confirmed that he would check on this.

157. On 25 January 2021 Cabinet met, exhibit **MD-7/076** - **INQ000129912** refers. Cabinet took into account several different papers, including one containing a snapshot of testing data, exhibit **MD-7/077** - **INQ000057759** refers. This confirmed that case rates had improved in most of Wales leading up to Christmas,

but that there were uncertainties in the data due to lags in reporting and low tests on Christmas Day likely followed by increases in testing. Case rates in most of Wales remained very high and were well above the threshold for Alert Level 4 restrictions, the impact of Christmas Day mixing was yet to show. This information was considered by Cabinet in making the decision to retain Level 4 restrictions until the next review.

158. Cabinet also had regard to a paper containing a summary of research carried out by Welsh universities on the impact on schools, exhibit **MD-7/078 - INQ000129921** refers. Universities had participated in a lateral flow testing pilot when students returned home for Christmas, the results of which showed a low positive test rate in students.

159. A further testing strategy for Wales was issued on 28 January 2021, a copy of which is exhibited at **MD-7/079 - INQ000227387.** The revised strategy reflected our greater understanding of the virus, the development of new testing technology and the roll-out of the vaccination programme, along with expanding the testing approach to include more regular testing for NHS and care home staff and patients in hospitals. Testing remained important as the vaccine was rolled out, not only to continue to safeguard the most vulnerable and protect the NHS, but also to consider how testing could be used as a safeguard alongside the vaccine as there was a return to normality. As a result of the new testing technologies, it had become possible to test at far greater scale, frequency and speed than previously.

160. The revised strategy focused on a number of priority areas, including:

a. Test to diagnose – testing patients on admission to hospital, patients who developed symptoms in hospital, asymptomatic inpatients five days post-admission and planned admissions to protect increased risk patients;
b. Test to safeguard – regular asymptomatic testing for NHS and care home staff, supported living staff, staff working with vulnerable people in special schools, domiciliary care staff and prison staff;

c. Test to find – continue to test anyone who thought they had symptoms to identify and isolate cases in the community, reduce transmission, support contact tracing, protect vulnerable individuals and help to slow or stop the spread of the disease;
d. Test to maintain – regular testing of the workforce in various settings to find cases and explore whether testing of asymptomatic contacts could allow people to safely remain at work or in school instead of isolating;
e. Test to enable – consider how testing might work alongside vaccination to enable people with a negative result or those who demonstrated the required level of antibodies in their system to travel internationally, attend work or cultural or sporting events or meet family and friends.

161. On the same day, a community testing framework was published which sought to build upon the pilot schemes in Merthyr Tydfil and Lower Cynon to test asymptomatic people to stop the spread of the virus. The learning from the testing trialled in Merthyr and Lower Cynon during late November and December 2020 and from other areas such as Liverpool had identified the potential of locally led, targeted community testing. The approach in Wales was to use a risk-based approach built on local intelligence and knowledge to target areas where active case finding would have the greatest impact in reducing harm. The Minister for Health and Social Services wrote to a number of stakeholders to include leaders of local authorities and local health board Chairs to communicate the issue of the framework. I have provided an example of this as exhibit **MD-7/080 - INQ000531772**.

162. On 19 February 2021, the Welsh Government published an update to the "*Coronavirus Control plan: alert levels in Wales (coming out of lockdown)",* which I exhibit as **MD-7/081 - INQ000081858**. Issued by both myself and the Minister for Health and Social Services, the plan highlights that alongside the vaccine, effective suppression of transmission through Test, Trace, Protect continued to be vital. The Plan confirmed that it had been shown to have a significant impact on rates of infection in Wales because of the way the people of Wales had engaged with contact tracers and isolated when asked to do so. This remained one of the most important tools we had to break the chains of transmission. The existing

network of test sites across Wales meant that people could get a test quickly and easily, with significant testing capacity and fast turnaround times through Public Health Wales and lighthouse laboratories. Given the increased risk of transmissibility of variants of concern, the ability to identify cases and follow up contacts remained important.

163. A framework for Covid-19 testing for hospital patients in Wales was issued on 30 March 2021, exhibit **MD-7/082** - **INQ000227308** refers. The Welsh Government's refreshed testing strategy published in January 2021 retained the already established testing priorities. These included the need to support NHS clinical care, by diagnosing those infected so that clinical judgements could be made to ensure the best care, and to protect our NHS and social care services and individuals who were our most vulnerable. The refreshed strategy continued to focus on supporting people receiving care and/or being admitted to hospital. It included testing to diagnose, to enable rapid identification of patients who were infectious, particularly those presenting to hospital so they could benefit from specific treatment for Covid-19. A confirmed diagnosis was also important to reduce uncertainty and the need for further investigations.

164. At a CDL call on 30 June 2021, exhibit **MD-7/083** - **INQ000216590** refers, I informed those present that testing rates in Wales were back to January levels and the Test, Trace, Protect system was under similar pressure as it had been in February 2021, which meant it would not take much for impacts in timeliness to emerge.

165. On 5 July 2021, exhibit **MD-7/084** - **INQ000129963** refers, Cabinet decided to create an Alert Level 0 in the Coronavirus Control Plan, to maintain some public health measures to keep the virus at manageable levels, until the vaccination rollout was complete, as recommended in the paper, exhibit **MD-7/085** - **INQ000129964** refers. That involved, amongst others, maintaining the Test, Trace, Protect programme. It was noted that the programme was funded through to March 2022 and, although its proportionality would need to be kept under review, it was considered to remain key to breaking chains of transmission, particularly given the potential of further variants of concern emerging. It was, however,

recognised that, although the existing legal duties on employers and individuals reinforced and enabled the system, they were not necessarily essential and may not be proportionate in the future. Pilots, behavioural insights work and research was underway to improve support for people self-isolating and would inform further advice on strengthening the Test, Trace, Protect system.

166. On 14 July 2021, Cabinet agreed that fully vaccinated adults no longer had to self-isolate from 7 August 2021 if they had been identified as a close contact with a person who had tested positive for Covid-19. I exhibit a copy of the Cabinet minutes at **MD-7/086 - INQ000129973**. I further exhibit a copy of the Cabinet paper at **MD-7/087 - INQ000271721** which sets out the clinical and expert rationale supporting the decision made by Cabinet, including evidence that vaccines were effective in reducing transmission and preventing serious illness. There was also mounting evidence that the harms associated with self-isolation were increasing, such as negative impacts on physical and mental health, incomes, businesses and public services. It was considered that, in view of the vaccine efficacy, the risk of harm associated with self-isolation could now outweigh the risk of harm associated with exposure to the virus. However, concerns remained over the risk of harm associated with nosocomial transmission in vulnerable settings. On the advice of Public Health Wales, Cabinet agreed that additional safeguards should be put in place before allowing health and social care staff who were fully vaccinated and identified as a close contact to return to work with those who were vulnerable.

167. At Cabinet meetings on 29 July 2021 and 2 August 2021, the minutes of which are exhibited at **MD-7/088 - INQ000057896**, the topic of self-isolation was revisited. Since the decision made at the former meeting, it was confirmed that the UK Government was considering the possibility of bringing forward the date for implementation to 2 August as a result of the number of key workers and others having to self-isolate after being contact-traced through the NHS app. Cabinet considered whether there was merit in bringing forward the planned changes in Wales. Input was considered from various sectors over current staffing levels and operational practicalities, with a number of changes required to have the change ready by earlier than the planned date of 7 August. Although the Welsh Government was on track with the majority of these, the Department of Health and

Social Care and the NHS Covid-19 App developer were engaged in making substantial changes to align with England's original timeline of 16 August and could not bring forward the necessary changes for Wales by 7 August or sooner.

168. Despite this, Cabinet was informed that there was potential for up to 500 Test, Trace, Protect staff to be fully integrated with the vaccine checking system by the following week with the remainder of the approximately 1,200 staff to follow afterwards to ensure the system remained stable. Although this could lead to the inability to verify the vaccination status of some contacts, this risk would be mitigated against by focusing tracing efforts on younger people who were less likely to be fully vaccinated.

169. Accordingly, and on 7 August 2021, fully vaccinated individuals and those aged under 18 were no longer legally required to isolate if they were identified as a close contact of a positive case.

170. On 28 October 2021, Cabinet agreed, upon consideration of advice provided by officials exhibited at **MD-7/089 - INQ000057940**, that if a member of a household (including those under 18 (but over 5) years old and those had been vaccinated) tested positive, everyone in that home should self-isolate until they had received a negative PCR test. At this stage, it was agreed that an exemption for 16- and 17-year-olds would remain in place pending further advice, most notably in relation to the impact on the exam system. The minutes of that meeting are exhibited at **MD-7/090 - INQ000022553**.

171. On 29 October 2021, I agreed advice seeking, amongst other matters, amendments to guidance to bring the above decision into effect. This advice (MA/FM/3639/21) is exhibited at **MD-7/091 - INQ000176896.**

172. At a CDL call on 17 November 2021, I raised concerns about the need to discuss the future of the National Testing Programme on a four nations basis at CDL calls. I had concerns as a result of officials becoming aware that there may have been plans by the UK Government for a radical reduction in testing by the end-March 2022. I reminded those on the call that the Programme was funded by money that would otherwise have come to the Welsh Government directly as a

Barnett consequential. As a result, it was my view that we should have been, but were not, adequately involved in determining the future of the National Testing Programme. The First Minister for Scotland shared my views and confirmed that the present uncertainty was causing recruitment and retention issues in laboratories in Scotland. A note of this call is exhibited at **MD-7/092 - INQ000216596**. There was always a tension in the UK Government between those who prioritised public health matters and those who attached greater weight to economic damage. By this stage, I felt that economic anxieties were leading the UK Government's response, and the rapid dismantling of testing capacity was driven by concerns over costs. I remained of the view that public health needs required a more gradual reduction. Despite the National Testing Programme being jointly funded, and despite having raised these concerns, the testing capacity reduction for all four nations took place at a pace determined by Ministers acting in this capacity for England only.

173. On 29 November 2021, urgent advice (MA/FM/4143/21) was submitted to the Minister for Health and Social Services and I in response to the Omicron variant. A copy of this advice is exhibited at **MD-7/093 - INQ000235900**. At this time, the position on the isolation of household contacts remained advisory meaning that the only legal requirement for self-isolation was for those who tested positive or all unvaccinated close contacts aged over 18 years old. We were aware that the UK Government intended to bring into force regulations on 30 November 2021 to require all contacts of Omicron cases to self-isolate in an attempt to slow down community transmission of this new variant. This was to apply to all contacts, regardless of vaccination status or age and included where there was suspicion of the Omicron variant, rather than needing to await confirmation.

174. Public Health Wales had been consulted and recommended that all contacts of probable and confirmed cases of Omicron should self-isolate and, on a precautionary basis, should not be released early even upon production of a negative Day 2 test result.

175. The advice provided several options for consideration, all of which could be advisory or mandatory as part of the existing regulations. The options presented at this stage were:

a) To align with the UK Government and require all contacts of Omicron cases to self-isolate (Option 1(a));
b) Alternatively, to require only household contacts of Omicron to self-isolate (Option 1(b));
c) To require all household contacts of all positive cases to self-isolate (Option 2);
d) To require all contacts of all positive cases to self-isolate (with no exemptions or test to release) (Option 3(a));
e) Alternatively, to require all contacts of positive cases to self-isolate (with a test to release for those under 18 or fully vaccinated) (Option 3(b)).

176. Officials recommended Option 1(a)and I agreed with this recommendation and I added that we may need to extend existing advice for all contacts to self-isolate until receiving a negative PCR test result at the next three week review. My response to the Ministerial Advice can be found at exhibit **MD-7/094** - **INQ000531820.**

177. On 14 December 2021, the Minister for Health and Social Services and I received a further discussion paper from officials. This set out options for self-isolation to be considered which included self-isolation for a period of 10 days, Daily Contact Testing, self-isolation for 5 days and LFTs for 5 days and self-isolation until receiving a negative PCR test.

178. At the regular Test, Trace, Protect meeting held with Health and Social Services Group officials on 15 December 2021, we expressed our preference for Daily Contact Testing on the assumption that awaiting a negative PCR test was likely to be unfeasible as a result of capacity issues with PCR tests. Officials agreed to provide further advice on the introduction of Daily Contact Testing and to review the feasibility of the use of PCR tests and this was received on 17 December 2021 under cover of Ministerial Advice (MA/EM/4382/21) which was

sent to both myself and the Minister for Health and Social Services for a decision, exhibited at **MD-7/095** - **INQ000361819**. This advice included at Annex 3 the discussion paper referred to above in paragraph 177. I agreed the recommendations in the Ministerial Advice, as set out in exhibit **MD-7/096** - **INQ000531821**.

179. The advice confirmed that, as the expected level of positive cases from the Omicron variant rose, there would not be the PCR capacity to deliver a PCR test to release unless there was significant reduction of demand in cases not connected to the new variant.

180. As to the introduction of Daily Contact Testing, this would align to the UK Government's approach of requiring eligible contacts to take lateral flow device tests for 7 days upon identification as a contact. The advantages of this approach included ensuring that the economy and workforce could continue to function. It also took into account the evidence at that time which showed that the Omicron variant had a high secondary attack rate (which was much higher in household compared to non-household contacts) and therefore Daily Contact Tracing as a precautionary approach was justified at that time..

181. There were also risks to its introduction, including that it could be perceived as a relaxation at a time of real concern and that demand for lateral flow device test kits would rise significantly, potentially compromising the sustainability of supply chains. Monitoring compliance would be challenging and there was a risk that take-up could be low. Officials advised that the decision between Daily Contact Testing and isolation was finely balanced but that, on the balance of harms and operational concerns, Daily Contact Testing was likely to be the most feasible option. We were invited to agree to introduce Daily Contact Testing for fully vaccinated adults and children aged 5 to 17 who were contacts of Covid-19 cases. It was recommended that this be introduced on 22 December 2021 (including for those already isolating) and that it be introduced as an advisory approach rather than a legal requirement.

182. The Minister for Health and Social Services and I both agreed to the recommendations for Daily Contact Testing and the revocation of the existing

Omicron measures in order to help relieve pressure on the contact tracing system and critical public services.

183. I attended a CDL call on 10 February 2022, a note of which is exhibited at **MD-7/097 - INQ000216612**. At this call, the UK Government confirmed that its plan for 'living with Covid' would concentrate less on testing and would focus on those most at risk, including testing for care, test to treat, test to manage outbreaks, international testing and testing to protect those who were most vulnerable. The UK Health and Security Agency confirmed that there were conversations ongoing at official level with the Devolved Governments and that it was likely to reduce asymptomatic testing and testing contacts at different speeds. It confirmed a recognition that, if the UK Government was to move quicker, there was a need for the UK Health and Security Agency to ensure that it could continue to support Scotland, Wales and Northern Ireland, even if provision had paused in England.

184. In response, the First Minister for Scotland made the point that, although the UK Government had the right to make decisions for England, she hoped there would be recognition that the Prime Minister's decision had funding implications that tied the hands of the Devolved Governments. She accordingly moved for a genuine four nations approach to discussion and decision making on testing, not simply discussions as to a decision already made by the UK Government.

185. I raised that a balanced approach needed to be maintained in unwinding protections. I considered pace and scale to be critical in relation to both testing and contact tracing capability. There were many jobs involved in both, and the transition needed to be managed in a way that did not have unintended consequences. I was particularly concerned that those who relied upon these jobs were not disrespectfully treated during the process. My biggest anxiety was how we would step things back up if needed if another variant of concern arrived. I advocated a need to consider the infrastructure needs and different ways that we may want to use it in future, recognising that we all paid to establish it and paid to operate it, in light of the deliberate decision not to use Barnett. The consensus at the end of the meeting was that the Chief Medical Officers of the four nations would work together to be in a position to give advice on phasing and timings.

186. On 1 March 2022, the Minister for Health and Social Services and I received advice (MA/EM/0728/22), exhibited at **MD-7/098 – INQ000177043**, upon the development of a Test, Trace, Protect Transition Plan by officials for the scaling down of testing and tracing services over a 16-week period to a 'steady state'. In 'steady state', Test, Trace, Protect was to be focused on protecting the most vulnerable, diagnosing for treatment, maintaining surveillance and maintaining capacity to respond to newly emerging threats. The plans were based on self-isolation for cases and contacts moving to an advisory basis rather than legally required.

187. We were advised upon several options for the transition period in the context of decisions by the UK Government. We accepted the recommendations of officials to utilise Option 3, which continued to provide support for testing to diagnose/treatment/test to safeguard and access for the public to lateral flow device tests for symptomatic testing and day 5/6 testing. Daily contact testing was to end with the asymptomatic testing offer, although there was to be provision retained for the more vulnerable. This option also had the support of Public Health Wales who confirmed it was consistent with the various advice it had provided on transition and steady state. In light of the improved public health picture and direction of travel towards the steady state, it was considered that this provided the proportionate approach to the transition phase. It also aligned with the changes proposed to the self-isolation duty providing lateral flow device symptomatic testing, alongside the change to guidance and the move towards personal responsibility. Confirmation of my agreement is exhibited at **MD-7/099 - INQ000531837**.

188. On 21 April 2022, the Minister for Health and Social Services and I received advice (MA/EM/1533/22), exhibited at **MD-7/100 – INQ000116746** relating to the Introduction of the Health Protection (Coronavirus, Testing Requirements and Standards) (Wales) Regulations 2022. As the provision of private testing services was expected further to expand to the general population as we moved into and beyond the transition period, officials were seeking to introduce an equivalent set of regulations in Wales. We agreed that the consultation process should commence on Regulations.

189. With gradual transitions in place, the Welsh Government self-isolation guidance came to an end on the 30 June 2022. Policy changed to general guidance which provided advice for people with symptoms of a respiratory infection, including Covid-19.

Part D: Equalities

190. I understand that the Welsh Government corporate statement sets out in detail the equality considerations in the development of the Test, Trace, Protect programme in Wales.

191. As a result of the focus of successive Welsh Governments upon inequality since the start of devolution, our early awareness of Covid-19 was informed by an understanding that every widespread disease outbreak is more likely to produce disproportionately adverse impacts upon those already socio-economically disadvantaged or suffering from some other pre-existing health condition. That general understanding was translated, from the start, into the actions taken by the Welsh Government. Uniquely in Wales, since 2010 the Welsh Ministers must have due regard to the United Nations Convention on the Rights of the Child, and we were used to doing so by the time of the pandemic. Of course, our specific appreciation of the impacts of this disease developed over time as the evidence of those impacts was gathered and presented to Ministers.

192. As detailed at the outset of this statement, the Wellbeing of Future Generations (Wales) Act 2015 promotes equality as an objective for society, not simply equality of opportunity. Consideration of the needs of vulnerable and disadvantaged people was central to the Welsh Government's decision-making throughout. Although we were conscious of the impact of restrictions on those who were healthy and economically secure, ensuring that we made decisions that would protect those most 'at risk' played a large part in our approach. This came into sharp focus early in the pandemic because of the emerging evidence of the differential impact of the pandemic on Black, Asian and Minority Ethnic communities. The evidence emerged from a small number of prominent clinicians

who observed in their own practice that their Black, Asian and Minority Ethnic colleagues were more vulnerable both to catching the disease and to the more serious consequences of it. As Wales has a smaller network of clinicians, and a closer set of relationships between frontline workers and decision makers, they were able to alert the Welsh Government to their anxieties.

193. In response, I set up the Black, Asian and Minority Ethnic Covid-19 Advisory Group in 2020 to examine the disproportionate impact of the virus on minority ethnic people and communities and the underlying reasons for this. Under the remit of this Group, Professor Ogbonna led a Socio-Economic subgroup, which published a report in June 2020. I exhibit the advice under which I was provided with a copy of this report at **MD-7/101 - INQ000144915**. This report made many recommendations and reflected the importance of appointing personnel on the ground who had trusted relationships, existing knowledge of the services and who could mobilise action by individuals and communities, as well as advise policymakers and health service providers.

194. In early-October 2020, by decision made by the Minister for Health and Social Services, this was carried forward by the appointment of dedicated Black, Asian and Minority Ethnic outreach workers in each health board to support the Test, Trace, Protect programme. As detailed in my Module 4 statement to the Inquiry, exhibited as **MD-7/102 - INQ000474420**, funding continued to be made available for outreach and engagement workers within each health board to support community engagement with the vaccination programme. This formed part of the Welsh Government's Coronavirus Recovery Grant for Volunteering, which was facilitated by the Wales Council for Voluntary Action (WCVA) to help support and sustain volunteering and community action during recovery from the pandemic. By March 2021, £2.5 million had been awarded to 27 organisations to help sustain volunteering and community action during recovery from the Covid-19 pandemic.

195. Although the socio-economic subgroup looked at the broader context for the disproportionality work, another subgroup also produced a risk assessment tool which was exported to other healthcare systems and other workplaces. These actions were taken in recognition of the fact that many Black, Asian and Minority

Ethnic colleagues were on the frontline and at risk of paying a disproportionately heavy price for their continued public service.

196. The Inquiry has received significant evidence upon the reports and recommendations arising from the Group and the action taken by the Welsh Government in response, including in my Module 2B statement that has been exhibited above. In relation to Test, Trace, Protect the following actions came out of the work of the subgroups and the Group:

a. Test, Trace and Protect developed a Black, Asian and Minority Ethnic Outreach Plan delivered by health boards in Wales. This had outreach workers engaging directly with Black, Asian and Minority Ethnic people and communities.
b. The Test, Trace, Protect programme engaged with Black, Asian and Minority Ethnic stakeholders and produced materials in a wide range of community languages to ensure that there was wide access to information that was essential to safeguard communities, including those from a Black, Asian and Minority Ethnic background.
c. Multilingual campaign assets for Test, Trace, Protect were developed, and the Welsh Government worked with UK Government teams on multilingual and diversity stakeholder mapping for the launch of the NHS COVID-19 app, and on developing assets on how to use the app in 11 different languages.
d. A community outreach toolkit was developed to present the important Test, Trace, Protect information and to encourage community leaders, third sector organisations and others to understand the key messages and address concerns on issues such as surveillance, immigration and scamming, and circulate these within their communities.

197. Alongside general equality issues identified by the Welsh Government, there were a number of 'hotspot' issues in relation to Test, Trace, Protect. In this instance, the equality issues come through to the surface more than the usual debates, meaning that we were very aware of them. Examples include the issues relating to testing of those in care homes (which I am aware will be dealt with by the Inquiry in another module), alongside the inequalities suffered by low paid

workers. In respect of the latter, there was a real fear (which turned out to be a realistic one) that some low paid workers would go to work despite testing positive because they could not afford not to. Supporting people to self-isolate was a concern that we had from the outset of the pandemic but as we were able to open up more sectors the impact on lower paid workers became more urgent. In October 2020 the Welsh Government established a Self-Isolation Support Scheme ("the scheme") for Wales, to remove financial barriers faced by people who needed to self-isolate. The scheme was adapted a number of times to expand the eligibility criteria and extend its length to ensure that those most in need could access financial support. The payment made under the Self-Isolation Support Scheme was initially £500 but was increased to £750 in October 2021, recognising that fewer people would be required to self-isolate. This took into account the new rules for vaccinated individuals. It also accounted for emerging evidence showing that unvaccinated groups tended to be in lower income groups and less likely to benefit from the option to work from home. Consequently, self-isolation for those groups would continue to be more challenging and more likely to lead to social and economic hardship. Equality issues were also very much alive in the debate regarding schools and how much of the system should be diverted to testing within that service.

198. Equality issues were relevant to all aspects of the Welsh Government's pandemic response. However, in respect of Test, Trace, Protect, they were more visible on the surface given the impact of self-isolation as outlined above. We were particularly aware of them and spent a considerable amount of time discussing them and deciding upon the appropriate action to be taken to address them.

199. An Integrated Impact Assessment on Test, Trace, Protect was carried out by officials under the portfolio of the Minister for Health and Social Services, a copy of which is exhibited at **MD-7/103 – INQ000182588**. I am aware that Jo-Anne Daniels has addressed this in her statement to the Inquiry in this module. I understand this was continually reviewed as the programme evolved and considered the impacts by protected characteristics and what steps were taken to address these, on the basis that all people should have access to the National Testing Programme.

200. Specifically, in relation to the testing element of the Programme, a key aspect was to seek to provide accessibility to testing for all communities, particularly those who would have difficulties and / or reluctance in accessing such services. This involved the setting up of Community Testing Sites and, later, Regional Testing Sites and even Mobile Testing Units which could attend at homes to facilitate testing where required, particularly for those who were vulnerable and could not attend at testing sites or use home testing kits. The Welsh Government sought input from a wide range of expert stakeholders in developing and implementing testing sites, which included Public Health Wales, local authorities, local health boards, charities and the third sector, amongst others, to ensure that the breadth of needs were identified.

201. Community Testing Sites in particular were targeted at assisting deprived communities and hard to reach groups with a high prevalence of Covid-19. I have addressed the expansion of testing using lateral flow devices elsewhere in this statement, and this also proved a valuable opportunity to support the more vulnerable members of society who could then test without leaving home.

202. In respect of the "Trace" element of the programme, Welsh language equity was a principal consideration in the deployment of the national contract tracing programme. The Welsh contact tracing system was developed so that individuals could report recent contact to local contact tracers, through the medium of Welsh, if that was their favoured language. As noted above at paragraph 196, we also developed multilingual assets for use for Test, Trace, Protect which covered a range of languages in addition to Welsh. The deployment of contact tracing teams who understood the local context was also a fundamental part of the development of the tracing programme.

203. 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.

204. In August 2020, the Welsh Government administered a survey to local authorities and county voluntary councils (CVCs) to collect information on how they were providing services for non-shielding vulnerable people, including their use of volunteers, and capacity to scale up if demand for services increased. The findings of that survey were reviewed and published on 16 December 2020, a copy of which is exhibited at **MD-7/104 – INQ000321007**. This recognised that many local authorities had adopted a proactive 'assertive outreach' with local area-based teams established within most local authorities to provide support for non-shielding vulnerable groups and individuals self-isolating as part of Test, Trace, Protect. This enabled effective triage and referrals to appropriate services and made it easier for residents to identify where they needed to access support quickly.

205. I have also set out in Part H below details of the financial support provided by the Welsh Government to those required to self-isolate under the programme.

Part E: Testing

206. As I set out in my M2B statement, we had to make decisions about the use of the available testing capacity and how to use it to the best effect. By mid-March 2020, the disease was so widespread in the community that testing was not telling us a great deal more than we already knew about sustained transmission in the community - community cases soon outstripped the supply of tests and existing systems were not capable of the rapid scale needed to meet demand. Community testing was introduced to try to deal with flare ups. However, testing in hospital settings still had a value — those in hospital had other vulnerabilities. The decisions about how to use our available testing capacity were determined by considering availability and what purpose would be served by using it in a particular way.

207. A decision was taken by the UK Government to end community testing on the 13 March 2020. As confirmed in the fifteenth SAGE meeting that day it was thought this would increase the pace of testing (and delivery of results) for intensive care units, hospital admissions, targeted contact tracing for suspected clusters of cases and healthcare workers. This included faster confirmation of

negative results. A copy of the minutes of this meeting are exhibited in **MD-7/105 - INQ000509415**.

208. The Technical Advisory Cell requested advice from SAGE on 15 March 2020 on the policy of standing down testing of individuals who were self-isolating. Instead, a policy of expanding community-based testing was to be considered e.g. through drive through facilities or self-testing through home kits (as with other conditions). Laboratory capacity freed up from reduction in other NHS activities could be redirected towards Covid-19 testing. The benefits of a rapid increase in Covid-19 testing in Wales were several-fold and included:

a) A better understanding of the epidemic and provision of greater intelligence for policy shifts e.g. lifting or imposing measures.
b) To be able to provide meaningful information to those who were self-isolating which would support greater compliance, as observed in other countries (e.g. Hong-Kong).
c) It would help, in future outbreaks, in identifying individuals who may not be at risk (e.g. for workforce purposes).

209. The Technical Advisory Cell recommended that this approach should be adopted with immediate effect. The Technical Advisory Cell briefing is exhibited as **MD-7/106 - INQ000300179.**

210. Public Health Wales at the time was working within the phased approach to tackling Covid-19 as outlined in the UK Coronavirus Action Plan - to contain, delay, research and mitigate. Public Health Wales issued a statement on 16 March 2020 confirming that 34 new cases had tested positive for Covid-19 in Wales, which brought the total number of confirmed cases to 94, a copy of this is exhibited **MD-7/107 - INQ000509416.** At that time, we were entering the 'delay' phase. This was now not just an attempt to contain the disease, as far as possible, but to delay its spread. As a result, Public Health Wales's advice for the public changed so people who thought they had symptoms of Covid-19 no longer needed to contact NHS 111, instead the public were advised to stay home and only contact NHS 111 if their symptoms worsened. The move into the 'delay' phase meant transitioning away from community testing and contact tracing. Testing would now

focus on cases admitted to hospital, in line with national guidance, and based on symptoms and severity. The move away from community testing was believed to give us greater capacity to test in hospital settings, where care for the most vulnerable pateints would be prioritised. Although there was no longer a need to identify every case through community testing, Public Health Wales still reported on Novel Coronavirus levels in Wales adopting a similar approach to that for seasonal flu reporting.

211. I made a statement to the Senedd on 17 March 2020 noting that our focus had shifted away from community testing, a copy of this is exhibited as **MD-7/108 - INQ000271921** . I said that "at this point in the progress of the disease, our focus has shifted away from community testing, because that is the best advice we have. Testing will now focus on people who are admitted to hospital, in line with national guidance and based on symptoms and severity. There is strong evidence from around the world that they can and will recover. This is about ensuring that our testing capacity is focused where there is greatest need. In addition to those in hospital, testing will now be made available to people working in key NHS clinical roles to ensure that they are not taken out of the workplace longer than is necessary. The number of these roles covered will extend as our testing capacity develops. Public Health Wales will continue its surveillance work to understand the overall picture in Wales."

Capacity

212. I recall a great deal of discussion in the early days of the pandemic about testing capacity. Public Health Wales had a certain level of capacity and was able to grow that capacity. However, as I have mentioned in one of my earlier statements, we learned quite soon that Public Health Wales was not geared up to being a delivery organisation on the scale that would be needed. That is not to say that it did not expand. It was able to do so and a great deal of investment in capital and consumables was used in doing so. However, Public Health Wales's normal way of operating was in relation to identifying and managing isolated outbreaks in parts of Wales and was not set up for all Wales mass testing and contact tracing purposes. It became clear that we would struggle to reach the testing capacity needed if reliance was placed exclusively on Public Health Wales.

213. On 21 March 2020, the Minister for Health and Social Services issued a statement in which he explained that the testing capacity in Wales would increase to 6,000 tests a day by 1 April, 8,000 by 7 April and a target of 9,000 by the end of April. A copy of that statement is exhibited as **MD-7/109 - INQ000509418**. The increased capacity set in March reflected work that was underway by Public Health Wales to increase testing capacity and included figures from an arrangement Public Health Wales had been thought to have agreed with Roche Diagnostic Ltd ("Roche") to procure test kits. The anticipated agreement between Roche and Public Health Wales did not subsequently materialise. I was informed by my officials that the agreement failed due to mis-communication of Wales' position by the UK Government who was also in negotiation with Roche. Roche entered an agreement with the UK Government to supply tests and Wales was allocated a share of these – around 900 per day. I understand this was significantly less than had been anticipated had the agreement been with Public Health Wales gone ahead. We had anticipated 5000 tests for Wales would have been made available if the agreement with Roche had been concluded. This was a source of disappointment and frustration. On 20 April 2020, the target of 9,000 tests by the end of April was unachievable.

214. I was not directly involved in the discussions with Roche but was made aware of the matters regarding the supply by them of test kits for use in Wales. I was copied into email exchanges about the situation, exhibit **MD-7/110 - INQ000533756** refers. In my recollection, Public Health Wales clearly believed an agreement had been reached for Roche to supply the tests directly to Wales. This agreement was then overtaken by a larger set of discussions between Roche and the UK Government. In the short term, this meant that Wales did not secure as much testing capacity as would have been available, had the original understood course of action been delivered. I referenced the fact that Roche was not going to be able to provide the test directly to us at a press conference on 6 April 2020, exhibit **MD-7/111 - INQ000533758** refers.

215. Alongside work to enhance testing capacity within Wales, the Welsh Government, together with the other Devolved Governments, worked

collaboratively with the UK Department of Health and Social Care to provide testing across the UK. The agreement with the UK Government was that Devolved Governments would receive a "Barnett" share of National Testing Programme capacity in lieu of the consequential funding which would otherwise have been derived from health spending in England. A copy of the agreement is exhibited as **MD-7/112** - **INQ000182594**. That meant that we could not create the capacity ourselves and the UK did not offer the resource on a financial basis. To put this in context, Public Health Wales' laboratory capacity was by 2021 around 8,000 tests a day, but with the ability to surge to 15,000 tests a day if required. We of course invested in the NHS Wales capacity with an additional £32 million into the Public Health Wales lab network. However, the 8,000 capacity was predicated on the fact that Public Health Wales had to deliver other laboratory services as well, and those other laboratory services were critically important to ensuring that we could support clinicians in their diagnostic and treatment plans.

216. The capacity in terms of the UK lighthouse laboratories was 30,000 tests a day, so it was significantly greater than we had available within Wales. Wales was entitled to a Barnett allocation share of the laboratory capacity available on a daily basis. The UK lighthouse laboratories network gave us a degree of flexibility to respond to surges in testing demand that would not have been possible on a Wales only basis. Being part of a wider network at a time of significant demand was important.

217. Although there were these clear benefits of being part of the National Testing Programme, the reliance on UK lighthouse laboratories was not as smooth as it could have been had four nations discussions and communications been better. Initially, datasets from the Welsh and lighthouse laboratories were treated separately which made data on both tests and cases difficult and risked duplicate entries. Public Health Wales, working with the Covid-19 analytical hub (part of the Welsh Government's Knowledge and Analytical Services), put in place a new method of data collection so the surveillance dashboard or data monitor would include a breakdown of the combined testing data by local authority.

218. As I have noted in my earlier statement to the Inquiry in Module 2B, there were undoubtedly problems with the lighthouse laboratories, which arose as a direct result of the difficulties inherent in trying to establish industrial-scale testing capabilities from scratch. The lighthouse laboratories were established at an enormous rate, very quickly, and at that speed and scale, it was inevitable that there were going to be some teething issues.

219. Wales was undoubtedly affected by those issues. We were not in charge of the laboratories, but were recipients and, on occasions, the service was not as good as we had hoped or been promised. However, in my view, the explanation for such occasions was the speed at which these were working and not because Wales was being unfairly treated.

220. When issues did arise, we were engaged in the conversations about their resolution. We knew about them in advance and were aware of the plan to overcome them. Although the lighthouse laboratories were not as good as we had hoped initially, they did improve. That was particularly so once a laboratory in Newport was set up, which was closer to us and in respect of which we were able to have direct dealings.

221. When considering the effectiveness of the National Testing Programme and the development of the testing infrastructure and capacity in Wales during the relevant period, I think it is important to stand back and look at the wider picture. There were hundreds of thousands of tests carried out in Wales for Welsh citizens that made a significant contribution to allow people to go on leading their lives and to, where necessary, enable them to take action to protect their own health and the health of others.

222. Another positive consideration is the sheer availability of testing and forms of testing. There were fixed test centres, mobile testing centres, testing capable of being delivered through the post, lateral flow devices, and so on. Over time, the variety of ways in which people were able to access testing was remarkable.

223. At a more detailed level, the picture was constantly evolving. For example, there was initially much debate between experts about the reliability of lateral flow devices for testing. Those turned out to be more reliable than early advice had led

to believe and could have been used to greater capacity earlier on had their reliability been known.

224. Another example relates to the location of some testing centres. For example, I recall that there was a particular centre in the Cynon Valley that did not have the benefit of a bus route. At that level of very fine detail, there were issues that had to be worked at to resolve.

225. The establishment of the testing centre at the Cardiff City Stadium was a more problematic example of matters not proceeding efficiently or effectively. As the Inquiry will be aware from its consideration of earlier modules, the UK Government took a decision to open a mass testing centre in Wales without any consultation or notice to the Welsh Government or any other relevant organisation in Wales.

226. This lack of communication and the speed at which it was established meant that basic things were overlooked and / or not properly understood in its set up. A clear example of this is the lack of consideration as to how a testing centre in Wales was to run effectively without the involvement of the Welsh NHS. Without their involvement, there was nowhere to which the results could be reported or used in the way in which they were intended to be. Following learning of its establishment, a lot of work was required to turn the testing centre into an effective one, which would have been avoided had there been early co-operation and communication from the UK Government as to its establishment.

227. That said, the above is most certainly not a typical example of the issues encountered, which were largely specific in nature and in the manner outlined above. My overarching view is that the big picture illustrates there was a system that was geared up very quickly that delivered mass testing, which made a highly positive difference to the ability for people in Wales to (i) lead their lives and (ii) protect their health and the health of others.

Testing Technologies

228. Under the terms of the Memorandum of Understanding for the National Testing Programme, exhibited above, the Department of Health and Social Care committed to inviting the Welsh Government to engage as partners with working

level discussions and developments in the National Testing Programme that materially affected Wales, where possible with appropriate time to consider decisions, and work with officials across the programme on all relevant issues such as new technologies, digital priorities, procurements, policy development, new testing services, etc.

229. The decisions around testing technologies largely sat with the Minister for Health and Social Services who has provided a statement in this module also.

Supply of Tests

230. I understand that the supply of tests has been set out comprehensively in the corporate statement of Jo-Anne Daniels. I have set out below my role and responded to direct opinion questions raised of me in the Rule 9.

231. The hard work relating to the supply of PCR and lateral flow tests in Wales was undertaken by officials. However, the status of that work was reported weekly to myself and the relevant Minister for Health and Social Services. For example, we would be informed of any forthcoming known limitations in the supply of tests or bottlenecks as a result of laboratories being unavailable and so on.

232. There was increased ministerial involvement in the early stages of the pandemic where testing capacity was entirely reliant upon Public Health Wales. This was due to the decisions on spending being made to facilitate the scaling up of their delivery capacity. Although this largely sat with the then Minister for Health and Social Services, I am aware that a review of testing was undertaken and published on 18 April 2020 which I have referenced and exhibited at paragraph 83 above.

233. Once we proceeded to the stages of mass production of testing, as set out above, ministerial involvement was limited to being regularly informed of how matters were progressing and expected limitations, but the day-to-day substantive work was being undertaken by officials.

234. The use of science during the pandemic to identify a vaccine and mobilise scientific solutions at remarkable speed is an important part of the story of the pandemic. However, as I've set out above, I do recall there was a running debate about the extent to which lateral flow devices could be relied upon as compared to PCR-testing. Lateral flow devices are, by their very nature, easier in terms of accessibility and speed. They can be utilised at home, without requiring people to travel to a test centre or wait for results.

235. As already indicated, my recollection is that there was some scepticism and hesitancy as to their initial reliability when compared to PCR testing. If their effectiveness had been known or if there had been initial greater confidence in this form of testing, some of the issues encountered relating to supply might have been capable of being resolved in a different way.

236. As to the effectiveness of engagement between the Welsh Government and the various relevant bodies and organisations in Wales involved in the planning, policy-making and roll-out of testing, I think there were strong levels of engagement between all that permitted each to play its role effectively. I consider that partnership working in Wales was a clear strength for us for the reasons outlined at the outset of this statement. As a result of our pre-existing relationships and the specific set-up of bodies such as the NHS in Wales, we were able to communicate and engage effectively and openly in matters relating to testing.

237. As I have already stated, I do think that the early reliance upon Public Health Wales demonstrated the limitations of its ability to act at the speed and scale that the emergency required, but that does not undermine the levels of engagement between Public Health Wales and the Welsh Government. Local authorities were instrumental in the sourcing of venues to be utilised for testing. There were a huge number of venues in Wales and considerable imagination was used in identifying these, whether from a showground in Carmarthen, to an ice rink in Deeside. The health service in Wales was also very agile in mobilising the workforce needed to run an effective programme. In all of the circumstances, I believe that the story of engagement within Wales is a strongly positive one.

Testing Strategies and Policies

238. I have set out above in Part C my role in respect of the testing strategies and policies issued during the relevant period.

239. As I said in my M2B statement, discussion of herd immunity could be found in newspapers and in scientific community considerations. It was never a practical position in Wales, and never proposed as such to the Welsh Cabinet. I stand by this statement and herd immunity was not a proposition that in any way translated into our Test, Trace, Protect strategies.

Review

240. My role as First Minister, in the review of the policies and strategies that had been adopted by the Welsh Government during the pandemic, was via the 21-day review process, namely the review of the principal regulations every 21 days. The success of the Test, Trace, Protect programme was measured against the evidence available at the time of the reviews and measures that had been taken to allow us to move away from non-pharmaceutical interventions. These comments and those made in this section reflect the position in respect of tracing and isolating.

241. I was also aware of specific reviews, one such review is exhibited above namely the review of the coronavirus testing regime which was published on 18 April 2020. The review described a range of delays and supply chain issues and confirmed that "we will not reach 5000 tests by the 3rd week of April". It included a commitment to provide weekly updates setting out expected and actual increases in testing capacity, an example of these weekly updates from 2 June 2020 is exhibited as **MD-7/113 – INQ000533782.**

242. In advance of each new testing strategy that was published, the Ministerial Advice which is referenced above, would set out reflection on earlier strategies and would set out how the process could be enhanced in the future. These developments framed the progression of the Testing, Tracing and Protect strategies.

243. I recall instances when I was informed of errors in the recording of test results. One example was in October 2021, when we were made aware of reports that a higher than expected number of positive lateral flow tests were resulting in negative PCR tests and this was being investigated by the UK Health Security Agency. The Agency identified that around 4,000 people may have been given inaccurate results and anyone who had a test from 4 October 2021 was contacted by the NHS Test and Trace and if they had received a negative result, they were advised to book an appointment to be re-tested.

244. When these incidents arose, we took them seriously, not only because of the harm caused by them which was relatively marginal in the scale of the entire programme, but due to the risk of undermining confidence in the system. The Test, Trace, Protect programme relied entirely upon the confidence of the public in it. If the public did not think that it could be relied upon, the behaviour of those using it would not be positively affected by it.

245. We were also aware that the tendency of media reporting was to focus upon these instances of errors, rather than to report upon the overwhelming balance of successful accurate reporting of test results. For that reason, we were upfront about sharing information when these issues arose, including by mentioning them in news conferences to ensure people were aware of not only what had happened but also what was being done to correct this and prevent re-occurrence. For me, it was vital to preserve people's confidence in the programme and assure them that any issues were being dealt with properly.

Part F: Test, Trace, Protect

246. I have exhibited above, at paragraph 101 the Test, Trace, Protect strategy that was published 13 May 2020.

247. On 1 June 2020, the Test, Trace, Protect programme was launched in Wales. Testing people with coronavirus symptoms, asking them to isolate from wider family, friends and their community while waiting for a result. Tracing people

who had been in close contact with anyone who tested positive, requiring them to take precautions through self-isolation for 14 days. Protecting the vulnerable or those at risk from the virus, providing advice, guidance and support, particularly if they developed symptoms or had been identified as a contact through the contact tracing process.

248. Advice to Ministers emphasised that testing was a critical part of being able to identify new Covid-19 cases quickly and was vital for surveillance so that the spread of the disease could be understood and clusters and hot spots identified. Testing helped to identify cases to enable contact tracing and self-isolation to attempt to contain the spread of the disease. It is only by identifying who was infected and, in turn, requiring those individuals and their close contacts to self-isolate, that the chain of transmission could be broken and the onwards transmission of the virus reduced.

249. The importance of the Test, Trace, Protect strategy was re-emphasised in the August 2020 Coronavirus Control Plan, exhibited above. The Plan confirmed that the decision for more widespread intervention, such as the introduction of local or regional measures to protect public health, would combine analysis of indicators with context specific intelligence. This included a range of sources, such as local and regional intelligence and insights from Test, Trace, Protect.

250. Under the Plan, the local and regional Test, Trace, Protect teams would identify complex cases or clusters of cases, which would then be referred from the local teams for investigation by appropriate professionals within regional teams and, where necessary, a multi-agency Incident Management Team would thereafter be established to investigate and monitor the situation. The role of the Welsh Government was to set priorities and provide resources to support the Test, Trace, Protect system.

Part G: Tracing

251. The role of Welsh Ministers generally in contact tracing was to agree and set the policy direction, bring together partners and coordinate activity across

Wales, along with agreeing the relevant funding. Insofar as the policy choices are concerned, it was agreed by the Minister for Health and Social Services in response to the advice received on 9 May 2020 (as exhibited above at paragraph 95) that these would be guided by five main principles:

a. The system was to be designed on the basis of a four nations approach to avoid confusion or undermining the behavioural response, with deviation only when necessary to reflect specific circumstances in Wales;
b. Maximisation of the contribution of social partners in responding to the public health crisis, which was generally consistent with Welsh Government principles and reflected the need for everyone to be involved in combatting the virus;
c. The system was to be designed to support citizens to contribute as much as they could to the process through a digital journey, in the hope that this would encourage positive behaviour and improve the effectiveness of the programme;
d. Strong steps were to be taken to support the digitally excluded, with such support to make use of the same digital systems;
e. The system should appropriately balance value for money with maximum health protection as, although responding to the virus was primarily a healthcare crisis, decisions such as these had to take account of the stewardship of public money.

252. I have already set out in the chronology those policy decisions in which I had specific involvement.

253. As set out above, Public Health Wales was thereafter responsible for establishing, implementing and operating the programme, with the implementation and operation undertaken in conjunction with local authorities and local health boards.

254. The development of contact tracing is one of the substantial differences between how matters proceeded in England, as compared to how they developed in Wales. I recall being made immediately aware of a conversation with the

Secretary of State for Health and Social Care, Matt Hancock, in which he had made an offer for Wales to be included in the tracing arrangements that were going to be implemented for England. Although not pressing for Wales to become involved, it was understood that the UK Government was about to embark upon a major procurement exercise to source an external organisation to undertake contact tracing. The options for the Welsh Government were either to receive the Barnett-consequential funding and undertake contact tracing ourselves, or to leave the funding centrally with HM Treasury and to sign up to the contact tracing service to be put in place for England.

255. In this case, it was decided that the appropriate course of action was for the Welsh Government to receive the funding and arrange our own contact tracing service for Wales and there were very clear reasons for choosing this option.The UK Government had decided to outsource its contact tracing system to a private company. I had a number of basic objections to this approach. Firstly, I was aware that Wales had a substantial number of public sector workers who were at home during the relevant period, either because they were shielding or because they worked in a sector that was unable to operate due to restrictions in place at the time. I was of the view that we could and should deploy those public sector workers for use in the contact tracing system. These were people who already had the public service ethos that is built into Welsh public services and I considered this would stand us in good stead.

256. Secondly, the contact tracing service is a service that absolutely relies on the confidence of its service users that the adviser to whom they are speaking is providing good advice. Public services are organised differently in Wales to England. We have unified local health boards not NHS Trusts providing secondary care services and separate arrangements for primary care services. We have 22 single tier unitary authorities in Wales, and they are not divided into county and district councils, as local authorities are in much of England. On a more local level, community and town councils provide services in their immediate areas. We also have County Voluntary Councils in place providing advice and information to local voluntary and community groups. Using the skills and expertise of Welsh public sector employees meant that good advice about broader services was also much enhanced.

257. Additionally, by deploying Welsh public sector employees, we were utilising those who were skilled already in approaching and speaking to people in the same accent of those people and from the place about which they were talking. I considered this was likely to be far more effective an approach in ensuring greater confidence in the service that was being provided.

258. Similar observations arise from a language perspective. It was difficult to see how an English-procured service could deal with Welsh language requirements and, even where service users were English-speaking, Welsh-specific matters such as pronunciations and spellings of the place names in which they resided.

259. As a result of these practical considerations and the differences in approach taken by the Welsh Government, I did not think that outsourcing these services to the private sector was the appropriate way to proceed. A further significant benefit of the manner in which the Welsh Government dealt with the set-up of the contact tracing service was that we were able to achieve it at a fraction of the cost that the UK Government spent in the procurement exercise in the private sector. This allowed us to free up some of the Barnett consequential funds for expenditure in other areas of the pandemic response, thereby enabling us to be more generous than our UK counterparts where we considered that the needs of the Welsh public and Welsh businesses required it.

Data and Privacy

260. This area sits more appropriately with policy officials, who I understand have provided a statement in this module.

Performance of Tracing Services

261. I was provided with a lot of very detailed information on a weekly basis. Jo-Anne Daniels has set out in the corporate statement that data was presented to ministers via:

a. Inclusion by officials in Ministerial Advice;
b. Technical Advisory Cell briefings;

c. Covid-19 Data Monitor;
d. Weekly Test, Trace, Protect Dashboard;
e. Covid-19 Situation Report; and
f. Covid Infection Survey

262. This information was also broken down into many different datasets, such as by period or geographical location. I have no doubt that the assimilation of all this data was a great burden on those who were having to record and produce it, but it was made as accessible as it could be.

263. The main lesson that we were able to take from the information provided was that during the periods that the disease was in abeyance, the ability to trace people was quicker and there was capacity to trace more people. It is during the peaks of the disease that the system struggles. Many people were ill and the sheer number of contacts had made it far harder to keep up with. To offer a brief illustration, if a workforce can process 80 cases every working day, then provided demand sits at 80 cases or fewer, then the system is in balance and new cases can be processed as they arrive. If, however, there is a surge and 120 cases need to be processed, only the system's maximum volume of cases (80 cases daily) can be completed leaving a balance of 40 for the next day, which fall to be considered together with any new cases. If the number of cases continues to rise, and more cases need to be 'carried over', then delays inevitably get longer. Essentially, the system works better when it is less needed and perhaps less so when it most needed. However, we had expert teams that assisted to boost capacity when those occasions arose. Having reflected upon this difficulty, I am not sure there is any feasible way of improving this aspect at times of maximum pressure, because it is at such a point that all aspects of the response are working at full capacity. It may be that we can learn ways of making the system work more effectively at other times (for example, where there is some spare capacity within the system), but not when everyone is already fully deployed.

264. The data provided was particularly helpful in allowing us to know where the pinch points were. However, these issues were essentially operational in nature

and were not necessarily a matter of policy that Ministers required a significant level of detail upon.

265. My view upon the performance of contract tracing over the relevant period was that it was pretty impressive. The extent to which contracting tracing changed transmission, and the course of the disease is a question to which, I am sure the inquiry will want to pay particular attention.

Part H: Isolating

266. On a general basis, the extent of my involvement in the isolation or 'Protect' aspect of the programme was much the same as with testing and tracing. However, there were certain aspects of the decisions upon isolation that raised policy issues necessitating ministerial involvement.

267. The principal example of this is the financial support to be provided to those that were being asked to isolate under the programme in order to protect their own health and the health of others. I will return to the issue of financial support shortly.

268. Before doing so, I also note that the question of isolation was one that was discussed at length at ministerial level. The scientific advice upon the length of isolation required changed during the relevant period and so decisions were required upon the appropriate length of isolation periods at various points. The approach of the Welsh Government generally was to take a cautious approach that factored in the scientific advice available at the relevant time, although balancing this against the other harms identified so as to avoid requiring people to isolate for longer than was necessary to protect the people of Wales and its health system.

Support for Self-Isolation

269. The question of support for self-isolation was one in which there was considerable ministerial involvement. We were acutely aware that many people in Wales would find themselves financially challenged if they were required to stay at home and not go to work. This became a more pressing issue as sectors opened up and as we approached autumn/winter period when we anticipated a potential

spike in transmission. From the start of the pandemic we had raised concerns with the UK Government at the Health Ministerial Implementation Group meetings and in correspondence in respect of the availability of statutory sick pay for those being asked to self-isolate. I understand Vaughan Gething, having led on this at the time, has outlined these efforts in his statement for Module 7. The questions raised and circumstances created by these matters were of interest to all Ministers across the Cabinet. There were many people not in the workplace due to the 'pingdemic' which spanned across all ministerial portfolios. This resulted in many ministers being involved in the question of how people would be appropriately supported during self-isolation periods.

270. There were occasions where we were able to be more generous than our UK-counterparts. The Minister for Finance had a particular role in this process as she was responsible for the use of the Welsh Government's financial resources generally during the pandemic. In the first year of the pandemic, she was assisted by the Star Chamber in this task.

271. A number of these decisions would have been discussed in Cabinet and, in my role as First Minister, I would have assisted in these discussions so as to reach a place where everyone was prepared to support a particular outcome. In other instances, questions of the relevant support to be provided would have been a matter for individual Ministers and their portfolio responsibilities. In the same manner as set out above, there would have been occasions when I was a direct participant in those decisions. By way of example, Self-Isolation payments were discussed at Cabinet on 18 October 2020, exhibit **MD-7/114 - INQ000048801** refers.

272. At a CDL call on 19 September 2020, we were updated on measures that the UK Government was planning to introduce the following week in relation to mandating self-isolation and supporting those required to do so. The UK Government confirmed that it intended to provide financial assistance, likely to be in the region of £500, to those on certain benefits that were required to self-isolate. Although that was to be an England-only scheme, we were assured that it would be subject to Barnett consequential funding that would enable the Devolved

Governments to distribute the money as appropriate. The Chancellor of the Duchy of Lancaster committed to share information regarding the support for self-isolation with the Devolved Governments. I welcomed the news of this financial support for those required to self-isolate and the confirmation that the Welsh Government would receive the relevant Barnett consequentials. A note of this meeting is exhibited at **MD-7/115** - **INQ000216546**.

273. I reported the outcome of the CDL call to Cabinet on 21 September 2020, the minutes of which have been exhibited at paragraph 118 above. There was some concern expressed that the UK Treasury could seek to take an alternative position and assert that there would be no further consequentials arising from this announcement. However, it was noted that the £500 isolation announcement had been made after the UK Government had confirmed additional financial support for the Welsh Government's Covid-19 response and so could not have been accounted for previously. It was also noted that Welsh Ministers were not responsible for income maintenance under the terms of the devolution settlement.

274. At the COBR meeting on 22 September 2020, the minutes of which are exhibited at paragraph 119 above, the Chancellor confirmed that, a mid-point review was due of the upfront Barnett guarantee provided to the Devolved Governments in July 2020. At that review, it was confirmed that details on the implications of the money for individuals self-isolating would be provided.

275. In October 2020, I received Ministerial Advice (MA/FM/3134/20) (jointly with the Minister for Housing and Local Government and the Minister for Finance and Trefnydd), exhibited at **MD-7/116 – INQ000103964**, seeking agreement to the provision of a support payment of £500 to individuals who were subject to mandatory self-isolation in Wales as a result of either testing positive themselves or because they were a close contact of someone who had, were on a low income, unable to work from home and would lose income as a result. The intention was for such a payment to assist in the removal of barriers faced by people who needed to self-isolate and would be in addition to the existing Emergency Assistance Payment coronavirus hardship element of the Discretionary Assistance Fund,

which is a programme of funding run by the Welsh Government and was available to a wider group of people.

276. However, it was recognised that there were risks to such a scheme. There was limited evidence about the levels of compliance with self-isolation and therefore it would be difficult to assess the impact of financial barriers and if such a scheme would improve compliance or not. There were also concerns regarding potential unintended consequences, such as additional 'fake' contacts being named to secure a payment or additional contacts deliberately generated. These later concerns were not regarded by the Cabinet as outweighing the advantages of providing self-isolation payments.

277. In order to ensure that the Welsh scheme benefited from the taxation and benefits disregard arrangements that were applicable in England, it was proposed that the Welsh Government provided a scheme that broadly matched the UK Government proposal insofar as the applicable criteria. The proposed criteria for Wales were:

a) That the applicant had tested positive for Covid-19 or was identified as a close contact of such a person by the Wales Test, Trace, Protect teams and had been issued with a letter advising them to self-isolate
b) The applicant was employed or self-employed;
c) The applicant declared they were unable to work from home and would not be paid their anticipated earnings as a result of the need to self-isolate;
d) The applicant was in receipt of Universal Credit, Working Tax Credit, income-based Employment and Support Allowance, income-based Jobseeker's Allowance, Income Support, Housing Benefit and / or Pension Credit.

278. There was a number of issues to clarify and work through which were detailed in the advice provided by officials as exhibited above. These issues were not insubstantial and did cause a delay in setting up the scheme in Wales. The UK Government had made clear that additional funding would be available to support these measures in England and verbal assurances had been provided that there would be a Barnett consequential for Devolved Governments. However, at the

point the policy was introduced in England, it was not clear whether this consequential was already accounted for in the money pre-committed to Wales or whether there will be additional funding on top of that. There were also taxation and National Insurance Contribution issues for individuals to be resolved. We needed assurance from the UK Government that individuals in Wales would be entitled to exemptions from which the English scheme would benefit. As these were reserved areas assurance needed to be obtained to ensure that the full benefit of the payment would be felt by Welsh citizens. I was advised that there were several delivery/payment options available and, in confirming my agreement to the introduction of the scheme, I confirmed that my preference was for delivery of the same by local authorities and for the payments to be backdated so as to be effective from the commencement of the firebreak lockdown, which came into force on 23 October 2020. I attach my email confirming this as **MD-7/117 - INQ000533766**.

279. On 16 October 2020, I was copied into advice to the Minister for Health and Social Services, the Deputy Minister for Health and Social Services and the Minister for Finance and Trefnydd (MA/VG/3045/20), exhibited at **MD-7/118 – INQ000493711**. This set out details of a scheme providing enhancements to the statutory sick pay available for the social care sector, particularly social care workers in care homes, domiciliary care workers and Personal Assistants. The intention was for this to operate alongside the Self-Isolation Support Payment scheme. The respective Ministers all agreed with the proposals set out.

280. In a Benefits and Harms paper prepared for Cabinet in November 2020 to assist Ministers in the consideration of the appropriate restrictions for the December period, it was confirmed that evidence from other countries suggested that compliance with the requirement to self-isolate was greatest in countries with a strong social safety net e.g. workers being paid to self-isolate. A copy of this paper is exhibited at **MD-7/119 – INQ000048897**.

281. As noted, and exhibited at paragraph 147 above, on 14 December 2020, the updated Coronavirus Control Plan was published and confirmed the

introduction of financial support for people on low incomes and social care staff set out above.

282. On 19 February 2021, the Welsh Government published an update to the "*Coronavirus Control plan: alert levels in Wales (coming out of lockdown)",* exhibited earlier in paragraph 162, which again confirmed the enhanced financial support scheme for people on low incomes and social care staff, along with practical support to help successful self-isolation. The Welsh Government also confirmed that it was working with local authorities to co-ordinate local support, including from voluntary and third sectors, to include befriending to combat loneliness, help with shopping, pharmacy pick-ups and dog walking services.

283. At Cabinet, on 5 July 2021, exhibited at paragraph 162, Cabinet recognised the need for adequate support for those required to self-isolate through Test, Trace, Protect and it was suggested that the lessons learned from the Covid-19 support hubs, which delivered the 'protect' offer to deprived communities, should be rolled out to other similar areas in Wales.

284. On 29 July 2021, I was copied into advice to the Minister for Health and Social Services, which advised on an increase in the amount payable under the Self-Isolation Support Scheme from £500 to £750. This was agreed by the Minister and came into effect on 7 August 2021. I exhibit a copy of the advice and the Written Statement confirming this increase at **MD-7/120 - INQ000136886** and **MD-7/121 - INQ000480077** respectively.

285. In January 2022, I was a recipient of Ministerial Advice MA/RE/4534/21, exhibit **MD-7/122** - **INQ000145583** refers. Under cover of which we were asked to agree that the self- Isolation Support Scheme payment return to its original sum of £500 from 24 January 2022 and that the Self-Isolation Support Scheme and the Statutory Sick Pay Enhancement Scheme were both extended up to 30 June 2022 to continue financially supporting people who may be legally required to self-isolate. My agreement is exhibited as **MD-7/123- INQ000533779.**

Part I: Other Decision-Making Relating to Test, Trace, Protect

Testing at the Border

286. I understand that Vaughan Gething MS has set out in his statement in this module the role that he undertook in respect of international travel and testing at the borders. I have set out below the particular role that I undertook in relation to these decisions.

287. UK borders are a reserved area as part of the reservation on national security, although ports policy and operations are devolved. I understand that the advice from the UK Department of Health and Social Care was that the most effective way to manage health protection measures at the border was to make legislation using powers in the Public Health (Control of Diseases) 1984 Act to address the proposals for information gathering, screening, assessment, self-isolation and quarantine at the border. To ensure a consistent approach across the UK, the UK Government advised that equivalent regulations under the 1984 Act would need to be made by Wales and that the Scottish Government and Northern Ireland Executive would need to use their equivalent powers under legislation in Scotland and Northern Ireland respectively.

288. The Joint Biosecurity Centre provided a weekly summary on the international case rates which would inform decisions around which countries posed an increased risk from travellers coming into the UK, I refer to this advice further below.

289. On 15 May 2020, I was asked to consider Ministerial Advice (MA/FM/1614/20), exhibit **MD-7/124** – **INQ000144889** refers, which related to officials working with officials from the UK Government and the other Devolved Governments on the development of a joint policy approach to international travel during the pandemic which I agreed.

290. Subsequently, and as I have set out earlier in this statement, the Health Protection (Coronavirus, International Travel) (Wales) Regulations 2020/574 ("the International Travel Regulations") were brought into force on 8 June 2020. The

regulations required certain persons arriving at ports from outside of the common travel area (the United Kingdom, the Channel Islands, the Isle of Man and Ireland) to provide information about where they would reside when in Wales and to isolate for 14 days following arrival. Later iterations included provisions on the requirement to isolate on returning from certain high-risk countries and on the requirement for testing to facilitate international travel.

291. The Health Protection (Coronavirus, Public Health Information for Persons Travelling to Wales etc.) Regulations 2020 (the 'Passenger Information Regulations') were made on 15 June 2020. These Regulations introduced requirements for operators of air and sea international passenger services to provide their passengers with information about coronavirus and related requirements (such as the duty to self-isolate when coming to Wales from outside the Common Travel Area), as well as information on public health guidance. That element of the Regulations came into force on 17 June 2020.

292. On 8 July and 10 July 2020, I was asked to consider Ministerial Advice (MA/FM/2236/60), exhibited as **MD-7/125** - **INQ000144975** and Ministerial Advice (MA/FM/2271/20), exhibited as **MD-7/126** - **INQ000144985**. These sought agreement to amend both the International Travel Regulations and the Passenger Information Regulations. Amendments to the International Travel Regulations were to add countries exemptions, namely so that persons arriving from certain countries or territories did not need to comply with the isolation requirements of 14 days. Officials also sought agreement to amendments to the Passenger Information Regulations to apply additional exemptions to the crew of aircrafts and channel tunnel workers so they did not need to provide travel information. I agreed the Ministerial Advice and the amending regulations. The Health Protection (Coronavirus, International Travel and Public Health Information to Travellers) (Wales) (Amendment) Regulations 2020 came into force on the 10 July 2020.

293. The requirement to isolate after being in one or more named countries or territories varied throughout the relevant period. By way of example, I was asked to consider Ministerial Advice (MA/FM/2574/20) on 06 August 2020, exhibit **MD-7/127** - **INQ000136805** refers, which advised that the Joint Biosecurity Centre had

updated its data and advice which re-categorised Belgium, the Bahamas and Andorra as "high risk" countries and I was asked that these three countries be removed from the exemption from isolation list. Likewise, the Joint Biosecurity Centre had re-categorised Brunei and Malaysia as low risk countries, and I was asked to agree the removal of the requirement to isolate for those passengers arriving from these countries. I agreed these amendments and the Health Protection (Coronavirus, International Travel) (Wales) (Amendment) (No. 4) Regulations 2020 came into force on 6 August 2020.

294. International travel lists and domestic vaccination certificates were discussed at CDL calls on 31 March 2021, exhibit **MD-7/128 - INQ000216574**, and 28 April 2021, exhibit **MD-7/129 - INQ000216583** refer. I cautioned that we needed to be very careful that certificates did not risk marginalising certain communities, so testing was an important part of the considerations as well as vaccination status. There would need to be exemptions for children and those with certain medical conditions. The use of certificates could even be counterproductive by having a negative impact on behaviour and providing a false sense of security. Other measures such as social distancing were proven to reduce transmission. There would be significant cross border issues if England were to roll out certificates and Wales did not. I was clear that international travel was the single biggest threat to sustaining the progress we had made, and the smaller the green list, the better. These concerns were picked up by the Minister for Health and Social Services at the CDL call on 26 May 2021, exhibit **MD-7/130 - INQ000216584** refers.

295. On 12 May 2021, I was asked to consider Ministerial Advice (MA/FM/1636/21), exhibited as **MD-7/131 - INQ000361820** which included the option of re-opening international travel although adopting a "traffic light system" with countries to be classified as green, amber and red, depending on their rates of coronavirus. The proposed traffic light system aligned with England and Scotland and the Joint Biosecurity Committee's Technical Board which had agreed a methodology for placing countries on red, amber and green lists. I agreed the recommendation of UK-wide action and recognised that preventing importing infection through international travel was an important means of controlling Covid-

19. The global position on emerging variants remained a significant driver for maintaining stringent border restrictions.

296. On 14 May 2021, I was asked to agree Ministerial Advice (MA/FM/1664/21), exhibited as **MD-7/132 - INQ000103975** the regulations that would give rise to the introduction of a new three level traffic light system for risk ratings of countries and territories; including a green list category where only one post-arrival test was necessary but isolation was not required; to agree that 12 countries and territories were added to the green list and that consequential changes were made to the Passenger Information Regulations and the Operator Liability Regulations to reflect the new circumstances, which I agreed.

297. The new international travel rules came into effect on 17 May 2021 and were set out in The Health Protection (Coronavirus, International Travel, Operator Liability and Public Health Information to Travellers) (Wales) (Miscellaneous Amendments) Regulations 2021. I issued a press release to confirm the position which is exhibited as **MD-7/133 - INQ000492892.**

298. As noted at paragraph 166 and 167 above, self-isolation periods were discussed in detail at Cabinet on the 14 July 2021, 29 July and 02 August 2021. Having fully considered the balance of harms, Cabinet agreed to remove the requirement to self-isolate for people who were identified as close contacts if they had been fully vaccinated for at least 14 days. This did of course, produce implications in respect of international travel and were reflected in the amendments to the Health Protection (Coronavirus, International Travel) (Wales) Regulations 2020. With isolation periods being reduced initially from 14 days to 10 days and subsequently to five days.

299. There was a Covid-19 Operations Committee meeting ('Covid-O'), chaired by the Chancellor of the Duchy of Lancaster, to which the Welsh Government was invited on 17 September 2021, exhibit **MD-7/134 – INQ000256905** refers. The new UK Travel Framework was agreed to be implemented in regulations. There was also a Covid-O on 17 September 2021 which was attended by a number of UK Government Cabinet ministers and the Welsh Minister for the Economy, exhibit

MD-7/135 – INQ000256906 refers. A discussion about testing requirements at the border took place and the Welsh Government raised a concern about the Delta variant.

300. There was agreement at the Covid-O on 4 December 2021, **MD-7/136 - INQ000256923** refers, to add further African countries to the red list and that all four nations would introduce a pre-departure testing requirement.

301. There was a further Covid-O on 5 January 2022, exhibit **MD-7/137 - INQ000256931** refers. The testing requirements were removed for fully vaccinated travellers, vaccine certificates were lifted, and the red list remained empty. I did not agree with this decision and wrote to the Prime Minister on 18 January 2022, exhibit **MD-7/138 - INQ000256933** refers, to set out the Welsh Government's significant reservations about the progressive erosion of public health protections against the risks posed by international travel. The Secretary of State for Transport responded to my letter on 23 January 2022, exhibit **MD-7/139 - INQ000256935** refers, emphasising the business case for relaxations. The debate on testing was continued at the four nations and Secretary of State call on 10 February 2022, exhibit **MD-7/140 - INQ000216597** refers and **INQ000216612** which is already exhibited at paragraph 183 above.

302. On 11 February 2022 all remaining quarantine requirements for vaccinated travellers arriving from abroad were removed.

Testing in Schools

303. From the earliest stages of the pandemic, we were keen to ensure that opportunities for education continued. For the children of key workers and for vulnerable young people, hubs were rapidly organised in each local authority so that face-to-face education could continue. We were able to make online learning resources available at periods when most school students were learning from home. As schools were able to reopen, we mobilised the social partnership approach, working with our public health, local government and trade union colleagues to create Covid-19 secure pathways to reopening. None of this is to detract from the very real impact which interruption to learning produced in the

lives of children and young people in Wales. For those many young people who received education through the medium of the Welsh language, for example, the reduction in face-to-face learning also reduced opportunities for language acquisition. The mental health impact, especially on young people preparing for public examinations, was always at the forefront of our minds. Throughout the pandemic we attempted to balance the right of children and young people to an education with the need to ensure that the physical well-being of students and staff was protected to the best of our ability.

304. Testing was central to ensuring pupils could safely return to schools and higher education facilities. I have set out in Part C above where I was involved in decisions relating to testing in schools and understand that education settings will be addressed specifically in a future module. The issue of school closures and re-opening is set out in my M2B statement also.

Part J: Public Communications

305. From the outset of the pandemic, I knew it would be essential that the people of Wales had access to clear, timely and consistent information on how to keep themselves and their loved ones safe. As the situation became more acute in March 2020, with rising cases and hospitalisations, the four governments agreed on a simple set of headline messages 'Stay Home, Protect the NHS, Save Lives'. For me, this summed up the contribution that each individual could make to preventing the spread of the virus, particularly to the elderly and vulnerable who were at greatest risk of severe illness. It also provided for consistent messaging throughout the United Kingdom, based on a similar policy position.

306. On 10 May 2020, I attended a COBR meeting where the UK Government unveiled its revised 'Stay Alert' messaging, which reflected the shift in policy in England away from staying at home and as I have set out in my Module 2 statements, it was at the meeting itself that the change in message by the UK Government was communicated to the Devolved Governments. I did not believe this was appropriate for Wales. We chose to retain a 'stay home' policy. I made the point forcibly that all messaging in Wales needed to reflect our policy and legal position. From this point on, our communications and public health messages

focused on the objectives and policy decided by the Cabinet in Wales. This was not without its challenges, and we made use of every possible channel at our disposal, including along the Welsh border where there was the greatest potential for confusion about the rules in place.

307. Throughout the pandemic I was determined that our communications response should speak to the people of Wales in a way that was clear, direct and honest. One of the important elements of this was daily televised press conferences where I, my ministerial colleagues and clinical experts spoke directly to people in Wales to provide the latest information about the spread of the virus, reinforce our public health messaging, and demonstrate that we were open to scrutiny and challenge.

308. I always sought to communicate in a way that was simple and straightforward and open about the many occasions on which decisions on restricting people's freedoms were finely balanced. Where the data was complex or contradictory, it was better to explain the dilemmas facing decision makers, rather than oversimplifying, or offer false certainty.

309. It was of significant importance to us that throughout the pandemic, when we made public announcements, they would be fully worked up and deliverable. I did not consider it a sensible approach to make commitments without proper consideration or confidence that they could be delivered in Wales. We considered the evidence, planned, and then made any necessary announcement. At times it may have led to different implementation timescales in Wales, but it meant we could deliver on our promises.

310. Welsh and English are both official languages in Wales and therefore our communications and messaging were bilingual throughout the pandemic. This was not simply a question of translating English into Welsh but also providing tailored messages that resonated with communities right across Wales. This meant people were able to receive public health messages in the language of their choice and with a tone that reflected public sentiment as closely as possible across different stages of the pandemic.

311. Likewise, engagement with 'community champions' and "trusted voices" were an important part of ensuring the Test, Trace, Protect programme was reaching and communicating to our communities in Wales. Community champions were faith leaders, community leaders, sports and cultural figures and were often respected figures within the community, this term was interchangeably used with the term "trusted voices" who were members of Public Health Wales, health professionals to include frontline NHS workers (doctors to include Muslim Doctors Cymru, nurses, GPs), life sciences and health academics. Again, they were trusted members of the community and would be regarded as mentors to those within the community and were engaged in order to increase confidence and trust within the programme.

312. Communicating public health messages during the pandemic brought high numbers of constituents into contact with their Senedd Members and Members of Parliament. Every week, we invested considerable periods of time in making sure that the Welsh Government's political colleagues had access to the best available information, including advice from the Technical Advisory Group's Risk Communication and Behavioural Insights Subgroup which was published and accessible via the Welsh Government website, so that they could play their part effectively in our efforts to provide the Welsh public with reliable and trustworthy information.

313. In relation to the Test, Trace, Protect programme, the Welsh Government had an important role to play in explaining to the Welsh public what they needed to do. The programme would feature regularly in public communications including press conferences, Facebook Livestreams and Q&A forums.

314. Local figures and respected members of the community also had a very important part to play in the implementation of this programme. If the Test, Trace, Protect programme was to work, it would do so because the citizens were aware of it and know that it was a system that was beneficial for them to use. Citizens needed to be aware of practical matters such as the locations, opening hours and access information for their local test centres. Much of that was down to local

communication and the Welsh Government relied upon local bodies to get that information to people in their areas.

315. On the whole, I consider that public communications 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 I have addressed elsewhere in this statement.

316. In relation to Test, Trace, Protect, I always thought that an additional challenge was that communications were often conveying, or were suspected of conveying, what might be well considered bad news about the need to self-isolate. People are usually more receptive to good news (for example, communications about vaccination) than bad. Test, Trace, Protect communications, while always about how to be better protected, also often conveyed news which would cause difficulty at the level of the individual.

Part K: Data, Modelling and International Comparisons

Sources of advice: medical and scientific expertise, data and modelling.

317. Other Ministers and officials will provide specific detail on the arrangements in place within their own areas of responsibility to obtain and understand scientific advice, data and modelling in relation to transmission, infection, mutation, re-infection and death rates in Wales.

318. However, in general terms, the core decision-making of the Welsh Government was informed throughout by medical and scientific advice. Throughout the 21-day review cycle Ministers would meet directly with the Chief Medical Officer for Wales, the Chief Scientific Adviser for Health and other

members of the medical and scientific advisory machinery. This would culminate in written advice to the Cabinet when core decisions were taken. Medical and scientific advisers attended Cabinet themselves. It was my practice to invite senior advisers to speak first in discussion of core decisions, so that Ministers always had access to the latest information.

319. As noted elsewhere in this statement, core decision-making was always based on the best evidence available at the time. It is important to note not every piece of evidence points in the same direction and different sources of evidence cast a different light on the same subject. Every piece of evidence is capable of being contested. That is why ministerial decisions were evidence based, and evidence informed but could not be predetermined by any single evidence strand.

320. I believe that the regard paid to such expertise by the Welsh Government went beyond 'adequate'. Every core decision involved the direct contribution of the best expertise available to us, and that advice was always considered with the highest degree of seriousness.

321. The issue with scientific advice is not whether you have enough of it – it would be wrong to assume that with more scientific advice decisions would have been different. In the end, scientific advice is just as vulnerable to ambiguities and uncertainties as any other advice. Decision making could not be reduced simply to the proposition that the right advice would lead directly to the right course of action. Moreover, in rapidly changing circumstances scientific advice also changes. Decision makers cannot always postpone reaching conclusions in the hope that better advice will be available in the future. Government decision-makers cannot conduct the business without exercising judgement.

322. The advice from the Chief Medical Officer for Wales and the Chief Scientific Adviser for Health was cogent and well-informed. They were well supported by advice from the Technical Advisory Group/Technical Advisory Cell, which produced briefings for the Chief Medical Officer for Wales who in turn advised Ministers. In order to be able to interpret SAGE advice for the context in Wales, the Technical Advisory Cell commissioned data gathering and modelling specific

to Wales. We had access to the Secure Anonymised Information Linkage Databank (which had been established in 2007 by the Population Data Science group at Swansea University, with core funding from the Welsh Government), to which we made available Welsh Government datasets to ensure they could be used by academic researchers who produced very sophisticated modelling. The Technical Advisory Group established a number of specialist sub-committees to ensure that it had the required range of expert opinion. The Technical Advisory Cell also produced consensus statements to enable a common understanding on important scientific matters.

323. As the Inquiry has heard already, Ministers are not scientific experts, but a good Minister will always challenge the advice provided. The word 'challenge' is best understood as a willingness and an ability to probe, to ask questions, to seek further views and so on, in order that a rounded conclusion can be reached. This was certainly possible. A good example of ministerial challenge can be found in relation to the advice on face coverings. The Chief Medical Officer for Wales was at the sceptical end of expert opinion in this regard, reflecting anxieties that wearing a face covering might give someone a false sense of security, and leading to a neglect of more effective behaviours. However, there were clearly alternative views available, and these were regularly rehearsed with him. I received written briefs from the Chief Medical Officer for Wales and received advice orally – I met with the Chief Medical Officer for Wales and the Chief Scientific Adviser for Health and anyone they brought with them, often the Chief Executive of the NHS, every week. That meant we were able to discuss the most up-to-date advice. The meetings always resulted in written advice if the advice required formal consideration. Such advice was usually captured by the 21-day cycle.

324. There was never any sense, once the initial lockdown period was over, that scientific and expert opinion was of one mind. We were always aware that even the same piece of information could be differently interpreted. These debates were known to Ministers, even when a consensus opinion was provided. Even consensus opinions were always presented as having high, medium or low levels of confidence behind them.

325. I think that, as the pandemic proceeded, we became more actively aware of the contribution which some perspectives – e.g. behavioural sciences – might make. The Technical Advisory Group, via its Risk Communication and Behavioural Insights Subgroup, provided advice on public behaviours which helped to inform our decisions around the imposition or lifting of restrictions. Understanding how our decisions would impact on behaviours and therefore the transmission of Covid-19 was an important factor in the decision as well as in how we framed our public communications. For example, in relation to Test, Trace, Protect we received advice on behavioural insights relating to contact tracing systems and young people. The advice explained how best to communicate with them the importance of engaging with Test, Trace, Protect, despite the general discourse that they were not at high risk of severe infection. A copy of this advice is exhibited as **MD-7/141 - INQ000066116.** In Wales, other interests such as economic and vulnerable groups, were always part of decision-making because of the way in which the Shadow Social Partnership Council was mobilised. However, it is important to remain aware that government is not a debating society. Ministers are, unavoidably, in the business of making decisions, using the best information available to them at the time, even when gaps in that information might exist.

326. Because of my own background as a social scientist, it was never my expectation that, in dealing with a wholly new set of circumstances, either data or advice (however expert) would simply provide the answer for Ministers. This would rarely be the case but was especially so because of the evolving nature of the pandemic and emerging variants. I fully appreciated that there was frustration for the public because some commentators were prone to implying that 'next week' fresh data or insights would be available which might resolve decision-making dilemmas. In reality, when that new information became available, it rarely acted in that way. More often, it simply gave rise to new questions for further exploration.

327. I was aware of the Swansea and Warwick models, but do not recall being specifically aware of the Rum or Canna model. However, I don't consider that it was necessary for me to be familiar with the technical construction of these difference models, nor of the specific detail of modelling data relating to Test, Trace, Protect.

328. I was generally aware of how modelling was being utilised to assist those who were advising upon the pandemic response. For example, I was aware that varying aspects in modelling meant that there was more than one modelling system being used and that each could predict different things and would produce difference results, meaning there should not be reliance upon one model alone. I was also aware that the modelling scenarios being produced would regularly change when further data was being fed into the same. I was thus properly aware of the limitations of modelling. Where there was information or data that I was required to be aware of, the Chief Medical Officer for Wales would provide the same and I was satisfied that I was in receipt of such data and / or modelling as I was required to be throughout the relevant period.

International Comparisons

329. Where international comparisons were available they were referenced in Ministerial Advice, Cabinet papers and/or advice from the Technical Advisory Cell which I have described above.

330. I understand that during the pandemic Public Health Wales developed an International Horizon Scanning work stream which focused on international Covid-19 responses, wider impact mitigation, transition and recovery approaches. An example of a report from 28 May 2020 is exhibited as **MD-7/142** - **INQ000068186**, which sets out the approaches to testing and contact tracing in a number of countries. Although I do not recall receiving these reports directly, they would have been referenced by the Chief Medical Officer and Chief Scientific Officer for Health in meetings, and as such, I was aware of this workstream by Public Health Wales. I am not aware of the degree to which these were shared with other governments in the UK.

331. I was also aware of the International Intelligence Technical Advisory Cell which was a sub-group of the Technical Advisory Group which evaluated emerging national and international research and evidence, including testing and trace measures, to identify lessons which would be applicable to Wales. I understand

this subgroup was established in September 2020 and was stood down in September 2022.

Part L: Lessons Learned / Facing a Future Pandemic

332. I contributed to the Covid-19 Lessons Learnt Exercise on the Welsh Government Civil Service approach to developing and implementing a cross-government response to the pandemic. I exhibit the report as **MD-7/143 - INQ000182549.**

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 that public health technicians were used to dealing with, by simply replicating the same thing on a larger scale. I consider there are questions as to whether, even if Test, Trace, Protect had worked perfectly as a set of techniques, it was the right set of techniques to respond to the outbreak of disease on such an industrial scale. I believe that the limitations of a Test, Trace Protect approach were clearly shown once it was applied on the mass scale necessary to address a pandemic of Covid-19's magnitude. Alternative approaches were visible in other parts of the world, ranging from the relatively laissez-faire approach of Sweden to the ultra-authoritarian measures of North Korea. Test, Trace, Protect, for all its limitations, was an attempt to find a middle way. With the benefit of hindsight, amongst the improvements which occur to me are first, that greater confidence could have been attached to lateral flow devices, with their capacity to foster self-management and second, a different calculation might have been possible concerning the optimum length of self-isolation, given the reductions in that period were applied as the pandemic proceeded.

334. I also question how much difference the whole industry actually made. On a much smaller scale, the ability to follow up on contacts made is far easier. People are aware that they have been contacted and recognise that their activity will be

under a spotlight and the subject of regular contact. However, I was always (and remain) uncertain as to whether or not the industry that was generated actually made a commensurate difference to the conduct of individuals during the pandemic. I am not aware of the evidence upon this to form a firm view, but think it is an important question for the Inquiry to explore.

335. When it comes to matters such as vaccination and PPE, it is clear to see that these made a significant difference to the pandemic response. However, I am not so certain that this is correct about Test, Trace, Protect. Testing, tracking and advising upon isolation was an enormous industry and I remain unclear as to whether it made a difference on the scale of the industry itself. It was relied upon hugely by the Welsh Government (and, I understand, our counterparts) but whether it affected the behaviour of individuals in the UK and changed the landscape of the pandemic is very much an open question for the Inquiry who will need to consider whether it was actually the right approach to take in the circumstances.

336. I think it is important to cite again the advantages of scale which are enjoyed in the Welsh context, when attempting to galvanise a collective response to a common set of challenges – such as planning and implementing a whole nation Test, Trace, Protect programme. Our long history of social partnership working underpinned a consistent effort to apply the public service ethos across the full range of responsibilities exercised during the pandemic. I remain of the view that the sense of common purpose and determination to mobilise every effort in pursuit of shared goals was one of the most striking characteristics of the Welsh response to the pandemic. I would want to emphasise again that this endeavour embraced all those who played a part, including non-devolved, as well as devolved services (the contribution of the armed forces, for example, was outstanding) as well as our partners in the private and third sectors, and the trades unions.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false

statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Mark Drakeford

Dated: 26/03/2025