

Tuesday, 15 July 2025

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2 (10.00 am)
3 **LADY HALLETT:** Good morning, Ms Paisley.
4 **MS PAISLEY:** Good morning, my Lady.
5 **LADY HALLETT:** Can you hear me?
6 **MS PAISLEY:** Yes, I can. I'm afraid I can't see you at the
7 moment.
8 **LADY HALLETT:** Ah, probably no bad thing.
9 Can you see Mr Gething?
10 **MS PAISLEY:** No.
11 My Lady, we think there might be an issue with the
12 Internet.
13 Ah, my Lady, I can see you both now.
14 Thank you, my Lady. The next witness is Vaughan
15 Gething.
16 **MR VAUGHAN GETHING (affirmed)**
17 **Questions from COUNSEL TO THE INQUIRY**
18 **LADY HALLETT:** Good morning, Mr Gething, welcome back.
19 **THE WITNESS:** Good morning, my Lady. Good to see you again.
20 **MS PAISLEY:** Thank you for attending the Inquiry today,
21 Mr Gething, and good morning. I believe this is the
22 fifth time you have provided evidence to this Inquiry.
23 Thank you for providing your witness statement to this
24 module, dated 3 April 2025. My questions today will
25 focus specifically on the response in relation to the

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1 vested in local authorities, and that social services
2 and social care are funded in a different way to health
3 services; is that all accurate?
4 **A.** That is correct.
5 **Q.** Mr Hancock, when he gave evidence to the Inquiry in this
6 module, said there was a hodgepodge of accountability
7 that meant that the levers we had at the centre were
8 weak in respect of social care. Is that something you
9 felt to be the case in Wales?
10 **A.** I wouldn't put it in quite those pejorative terms. The
11 accountability lines are different. The NHS is
12 essentially line-managed by the Welsh Government; social
13 care is a function of local authority. So the levers
14 are different.
15 The sector, though, is organised in a very different
16 way, and as I said in my statement, and others, I'm
17 sure, have as well, there are challenges about the way
18 that the sector is organised, about directly provided
19 care, and indeed the range of private providers that are
20 commissioned by either the local government or the NHS.
21 **Q.** Can you provide an overview of any difficulties caused
22 in respect of the organisation of the sector in as far
23 as the response to the pandemic, please?
24 **A.** Yes, I think I covered this in my statement, there were
25 at the time about 1200 care homes in Wales of a variety

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1 adult social care sector.

2 By way of brief background, and you give further
3 detail in your written statement, you have been a member
4 of the Senedd since May 2011. You were first appointed
5 as a deputy minister in June 2013, and during the
6 pandemic you held two ministerial roles; firstly, you
7 were the Minister for Health and Social Services,
8 a position you held prior to the pandemic and held until
9 May 2021, and you were then appointed as Minister for
10 the Economy; is that correct?

11 **A.** That is correct.

12 **Q.** You explain at paragraph 11 of your statement that your
13 responsibilities in relation to social care were
14 fundamentally different to your responsibilities in
15 relation to health. The Welsh ministers are responsible
16 for the promotion and provision of a comprehensive
17 health service in Wales, which includes the provision of
18 hospitals and other services or facilities as required
19 for the diagnosis and treatment of illness.

20 There is no equivalent statutory duty in relation to
21 social care, although Welsh ministers do have a range of
22 powers and functions under the 2014 Act and are
23 therefore responsible for the decisions made with
24 regards to those functions.

25 And you explain that statutory responsibilities are

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1 of sizes. Most of those are privately run. You have
2 quite small care homes in some instances, essentially
3 converted large houses, and the odd purpose-built care
4 homes that are much larger, so there's a variety of
5 providers. There are some fairly significant groups of
6 provision, and very individual care homes as well. Some
7 of those are residents who directly pay for their own
8 care, others have commissioned care, largely by local
9 authorities, and when there is nursing care available,
10 sometimes it is the NHS that is commissioning that care,
11 as well.

12 So the sector is in a difficult position compared to
13 the NHS where you have one stream of accountability
14 going through the service. And, of course, it is not
15 one that the Welsh Government directly line-manages
16 either. We do have overview responsibilities, as I set
17 out in my statement.

18 The sector is also relatively poorly funded and we
19 have challenges around staff, age of staff, some
20 post-Brexit challenges about the numbers of staff, and
21 I just want to raise the esteem in which the service is
22 held -- and regular challenges about pay, as well. It's
23 a relatively low-paid sector of the economy.

24 **Q.** Mr Gething, some have described the social care sector
25 as the "Cinderella" service of public services,

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1 including the adult (sic) Directors of Social Services
 2 Cymru; is that a statement you would agree with?
 3 **A.** I recognise where that comes from because it's
 4 relatively low paid but actually it's hugely important.
 5 It employs very large numbers of people. Most of those
 6 are women. And I think the public don't really
 7 appreciate the residential social care sector and the
 8 domiciliary care sector, because it is not as visible as
 9 the health service. And I think when people interact
 10 with that sector, they're then surprised that it doesn't
 11 have more to it.

12 And, you know, it's a sector I'm familiar with
 13 myself, not just as a minister, but, you know, I've got
 14 family who interact with the sector as well.

15 **Q.** Two more general questions, please. Firstly, in your
 16 view, did pre-pandemic plans and indeed the response
 17 over the pandemic in Wales in any way overlook the
 18 domiciliary care sector?

19 **A.** I wouldn't want to say yes with confidence to that. You
 20 see, the domiciliary care sector, where care is provided
 21 in someone's private home as opposed to a care home,
 22 although for some residents, the care home is their
 23 home, I think there's always a challenge about the
 24 variety of the tasks the domiciliary care sector
 25 undertake, from relatively intimate ones to lower level

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1 you know, to be blunt, there are plenty of ministers who
 2 are acting as unpaid carers in roles within their own
 3 families. Not of the range of significance that you
 4 might hear described through the evidence, but it's
 5 a sector that I think does bear greater attention in the
 6 future.

7 **Q.** Mr Gething, can I please now move on to hospital
 8 discharge in March 2020. Now, you have given evidence
 9 about this topic, including the emerging evidence on
 10 asymptomatic transmission in other modules of this
 11 Inquiry, and the Inquiry will of course consider all the
 12 evidence you've provided, but I do have a few questions
 13 arising, please.

14 In your Module 2B statement at paragraph 493, you
 15 explained that at the time of your announcement of the
 16 framework of actions on 13 March 2020, the testing of
 17 asymptomatic patients being discharged from hospital was
 18 not discussed with you. You say in the same statement,
 19 at paragraph 171, that there was a paper from SAGE on
 20 3 March 2020 which said that asymptomatic transmission
 21 could not be ruled out.

22 In Module 7 this year, on 20 May, you were asked if
 23 you were aware of the possibility of asymptomatic
 24 transmission by the time of Mr Drakeford's statement to
 25 the Senedd on 24 March 2020, in which he said:

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1 tasks, as well, but actually, from a funding point of
 2 view, actually, the provision of that care from a local
 3 authority commission service, the need level has gone
 4 up, not down. But there's always a challenge in, and
 5 I'm sure it's one of the things we'll look at in terms
 6 of lessons learned, about factoring in both care home
 7 provision as well as domiciliary care in someone's own
 8 private home as well.

9 **Q.** Can I ask, please, the same question in respect of the
 10 response with unpaid carers. So did pre-pandemic plans
 11 and the response over the pandemic in any way overlook
 12 the provision of unpaid care?

13 **A.** I think the scale of unpaid carers was something that
 14 was very apparent in our mind in a whole range of areas,
 15 but when it came to pandemic planning, I think it is
 16 again one of the lessons to learn about how do you
 17 support unpaid carers.

18 The voice of unpaid carers was, I think, pretty
 19 significant throughout the pandemic. In all of our
 20 weekly press conferences there were representatives of
 21 unpaid carers asking questions, so it was regularly
 22 a feature in the minds of ministers that were going
 23 through it. But I do think for the future it's an area
 24 to focus on again, to think about how do you properly
 25 support the very large numbers of unpaid carers. And,

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1 "... while you [were] asymptomatic you could be
 2 passing the virus on to somebody who [was] much more
 3 vulnerable."

4 And that fed into the decision to stay at home.

5 And you said it was a possibility.

6 Even if it was not specifically discussed with you
 7 in respect of the framework on 13 March, would you agree
 8 by that date, that you were aware of the possibility of
 9 asymptomatic transmission, and that it could not be
 10 ruled out?

11 **A.** I'm not sure that by 13 March I could say that I was
 12 aware of the possibility of asymptomatic transmission.
 13 We've discussed transmission, and the clear evidence and
 14 advice was: symptomatic people were at risk. But that
 15 doesn't mean that it couldn't be ruled out. So I think
 16 that's a fair answer to the question you put, that
 17 I certainly wasn't aware of asymptomatic transmission
 18 being a real risk, but that doesn't mean that I could
 19 say it had been positively ruled out. And that's the
 20 level of uncertainty upon which decisions have to be
 21 made.

22 **Q.** I'm grateful, Mr Gething. So you accept that it
 23 couldn't be ruled out. That's a fair way of putting it?

24 **A.** I think that's a fair way of putting it.

25 **Q.** When you made the announcement on 13 March, had you

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queried or challenged the advice you were receiving, given the implications that the possibility or, in your words, the fact that asymptomatic transmission could not be ruled out? So the impact that may have on the adult social care sector in the light of expedited discharge?

A. I think the challenge is that, in agreeing that framework of actions on 13 March, the clarity of advice is around symptomatic people, and they are a definite vector, potential vector, about being infectious. It's also because, by this point, the really harrowing scenes in northern Italy had played out and the risk isn't neatly packaged up in one part of society.

As we know that Covid is spreading through the UK, largely from an introduction from Europe from February half-term visits, there's risks in hospitals, there's risk in the community and there's risks in every other sector outside hospitals as well. And we know, I'm afraid -- well, we're pretty certain -- that if people who don't need to be in a hospital any more are still in that hospital, then not only is there a risk in normal times of them coming to harm, that's what happens with delayed discharges, but actually, if we're having more people with Covid who need an acute hospital bed, then we will see harm throughout our sector, and that is disproportionately harm that affects older people.

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reduced risk if you had been able to test on discharge, and that would also have relied on not just capacity but the speed of turnaround of testing as well, because if you test someone and you get the results back 36 hours later, there's no guarantee you've eliminated the risk.

So at the time that wasn't the advice. It wasn't in front of me, so I don't think I would be able to say that I could and should have gone behind and around that advice, but in hindsight there's plainly a different range of considerations that we could have made at the time.

Q. And therefore looking forwards, which is part of the purpose of this Inquiry, in these circumstances, do you agree that it would be sensible to have that precaution in place in the future?

A. Yes, but there's a but, and it's a pretty significant but. It does depend on whether you've got the tests available, the speed of the tests available, and you still have to look at the balance of harm and risk. Because as I say, if you know you're going to have lots of people coming into a hospital who need care and will suffer and potentially die without that care, you've got to balance that against what you do across the whole sector, and it also depends on the nature and the state of the scientific evidence and advice at the time,

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It's -- the core business of NHS hospitals is older people at any one point in time, in terms of people in a bed. So you're dealing with risk right across the spectrum. And it's about where and how you balance that risk, knowing that the majority of that risk is going to come into your hospital in the coming days ahead.

Q. Mr Gething, do you agree from 13 March 2020, at the very least, there should have been a policy for all new admissions to care homes who had not been tested and were going to be discharged into a care home, that they should have been isolated upon admission?

A. Well, that wasn't the evidence and the advice we had at the time, and it depends on whether you're asking me based on what I knew at the time, the advice I received at the time, compared to what I know now. Because they're two different points, aren't they? The advice and the evidence at the time was that this was the way, the right way to strike a balance. And there was no advice that came to me saying, "You should test everyone who was leaving a hospital". That advice was never provided to me at this point in time.

And I think it's very hard to re-second-guess all that and say at the time you should have known? Well, actually, I didn't. Looking back, though, of course in hindsight you can see that actually you could have

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because I can't predict for you now what the next pandemic will be.

It could be something, because coronavirus up to this point wasn't thought to be transmissible unless people were symptomatic. It might not be a coronavirus in the future. If we were dealing with a transmissible disease where asymptomatic transmission was a possibility, and you have the ability to test, and to test rapidly, then yes, it's something you should do at the start. But whoever the decision maker is will need to deal with the level of certainty and uncertainty they have in the face of the next pandemic.

But in hindsight with this pandemic, if we'd been able to test on discharge from hospital, we could have eliminated risk and as importantly, I think, maintain confidence within the residential care sector as well.

Q. Thank you. I think we may be conflating two separate issues. At the moment, in respect of the fact that there was not enough testing capacity, in your evidence, at that time, do you agree that in those circumstances, where there is limited testing capacity, it would be sensible to isolate people if there isn't an opportunity to test them?

A. If there isn't an opportunity to test, then using isolation as a part of that, yes. And then you're into

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making sure you have adequate PPE for people and you need step-down facilities for people to go into. And more modern care homes do have isolation facilities. If you're looking at other isolation facilities, you've got to identify where they are and how you protect a resident population in any closed setting. So they're different factors, aren't they?

If you have enough tests there's one thing you can do, particularly on the speed of the test. If you don't have enough tests, then you've got to consider isolation as one of the additional measures.

Q. Thank you. And one of the steps taken in Wales from 29 April was step-up/step-down guidance. Is that something you think should have been brought in earlier than 29 April?

A. I think we made a concession on this, haven't we, in terms of the fact that once a decision has been made, I think on 15, 16 April, and is then communicated in a letter to care homes --

Q. Yes.

A. -- about what we're going to be doing, I think that's 22 April that letter goes out, or the guidance still is another week. It is also still about making sure you've got enough step-up and step-down provision and where that provision is actually located, because some care

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to either their own private home on a normal street or flat, or indeed, if their home is a care home, when and how they return there.

Q. Can we now, please, and I think you have just touched upon it, the decision about testing and the capacity. And in Module 7 you said:

"Not testing patients on discharge as a matter of routine was in line with advice from Public Health Wales and [SAGE] on prioritising tests for best effect. This was ... based on understanding of transmission at the time."

And I think your evidence to us today is that that was the evidence you were receiving at the time; is that right?

A. Correct.

Q. Now, in Module 2B, when discussing asymptomatic transmission more generally, you gave evidence that you think, actually, if you have greater testing capacity, you can do a great deal more. And then just finally one more piece of background before my next question. In a press conference in June 2020 you said that testing capacity had no bearing on the original decision not to test people without symptoms going into care homes, and you said:

"If we'd trebled the amount of testing capacity at

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homes have more of a challenge with doing that and then in some parts of the country you may be able to use other NHS facilities as a step up and step down.

Q. And would you agree that this is something that needs to be thought about in planning for a future pandemic, the availability of those settings to care homes that may not be able to offer isolation?

A. Yes, and it also goes in with your means and ability to do so, how quickly you can do it. So for example, when we created a field hospital network in Wales, it took time to do that. You've got to identify the areas, you've got to get them staffed and ready. But that then essentially gives you more flexibility to do this with the numbers you potentially need, as well. But part of our challenge is that we don't build into the way we run our health and social care system lots of additional capacity that is unused.

So, you know, care homes need 90% occupancy plus to be financially viable at present. So there isn't lots of additional capacity built in to flex around that. If you're facing a pandemic, though, and you recognise you need more, it is entirely reasonable to plan for: how could you flex up and provide more step-up and step-down capacity, you need to have somewhere outside of an acute hospital setting to care for people before they return

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any point in time, then that was still the evidence and advice we had on how to make use of all of our resources. We did not get advice that said 'You really should do this but can't because we don't have ... capacity.' To make a link between testing capacity and the choice we made is not borne out by the facts."

So my question is: if in fact you did have treble the testing capacity or more testing capacity, do you think that could have impacted on the decisions that were made, or do you stand by those comments made in June 2020?

A. No, I think it's still the case that that was the evidence and advice at the time, and it would be wrong for me to try to recast my evidence based on the advice we had at the time. Separate to that, it is of course possible that if you have lots more testing capacity, how you use it and how you prioritise that can change and give you more flexibility because that testing capacity isn't just for Covid. I think we've been through this before in my previous evidence. That testing, that lab capacity is also testing for a range of other conditions the health service needs to be able to provide for, including during the pandemic. But if you have more capacity, then the way that you prioritise the use of those resources, based on the advice, can

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change, as well.

And so, you know, it isn't just my evidence on the state or not of asymptomatic transmission, I know Chris Whitty, his Module 2B evidence runs through the changing, understanding and knowledge about transmission.

So at the time that was the advice, and that was the choice I made based on that advice, but if we had had more capacity then we would have run through our list of priorities of how to use that capacity in a way in which we could have done.

Q. So perhaps your evidence today is not quite as strong as the statement made in June 2020 that you definitely wouldn't have done it. You might have done it; is that fair?

A. But the statement I made in June 2020 was reiterated. That was the evidence and advice I had at the time. And I didn't have alternative advice that says, "Use this in a different way", and actually trying to forecast what you might do with different resources is actually really hard and I think you're getting into a really hypothetical position there.

When you're giving and delivering that press statement, particularly with the challenges that the country is facing, then it's very hard to engage in

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provided.

And of course Public Health Wales are, if you like, leading the way on the guidance for care homes at the time. In fact it's Public Health Wales's guidance that is essentially published and delivered for care homes at this point in time.

Q. So specifically, then, the numbers of hospital discharges to care homes, you would agree that that would be useful for them to have in the future?

A. I can see how it would be useful, but not just in itself, because it is both the number of discharges, our understanding of the science on discharge in itself with or without a test, our ability to do that, what the pandemic is in front of us, and how that affects the ability of those care homes to handle those patients. Because there is a point given of reasonable contest: can every care home manage every patient? And in normal times they can't.

In the pandemic that's also a factor as -- I know that came up in conversation with a range of stakeholders.

So it isn't just about providing more data; it's data for a purpose, to try to give you a more joined-up answer.

I think my understanding is that's essentially what

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hypotheticals, because part of your job is to both explain choices and provide a level of reassurance about the evidence base you have to work with. And that's what I was doing.

Q. Professor Khaw of Public Health Wales told the Inquiry earlier in this module that Public Health Wales did not have access to the numbers of hospital discharges to care homes. Given that they were responsible for advising on testing, do you agree that, in the future, that's important information that they should have access to?

A. I think it's important that Public Health Wales are properly part of the way in which we deliver a response to a pandemic in all aspects. That's hospital discharge and a range of other things as well.

In terms of the initial period of response, I think it is fair to say that we needed to draw our system together in a way that we hadn't had to before, because Public Health Wales has led on localised outbreaks but they couldn't lead in that same way on this national pandemic. So understanding that data would be helpful for everyone, but of course, on a local level, where we had incident management teams, Public Health Wales were engaged in that as well. And it's really about what data we're talking about, and when it needs to be

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Professor Khaw was saying, and I don't take any dispute with that.

Q. Just a few more short questions, please, on 13 March before we move on. Mr Gething, you've frozen on my screen -- thank you, you're back.

At paragraph 95 of your Module 6 statement you say that in the briefing you received on 13 March 2020 it said:

"... the national Pandemic Flu plan provided a framework of actions and that every health organisation had an extant plan which they had been in the process of reviewing and amending the preceding month."

Did you ask whether there were any similar plans in respect of the care sector about how they would cope with the implications of such a framework?

A. My understanding is that for the pandemic plan, that care homes had plans around what to do with flu -- with a flu pandemic and the intake for that. And of course, we're -- in normal times, in the middle of March, you're at the end of the normal flu season and, you know, sadly flu takes the lives of people every year, including in the residential care sector. And when you have infectious conditions, whether it's flu or D&V, in a care home, part of the challenge is there are supposed

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1 to be existing isolation facilities.

2 I think the challenge here was the scale of those
3 isolation facilities and the adequacy of them in each
4 care home, because this is a bigger and even more
5 important consideration.

6 But it's the point about having the plan about the
7 way that the local NHS and social care providers are
8 supposed to be able to work together to implement those
9 plans for a pandemic.

10 **Q.** And you've said it's your understanding that there were
11 plans. Were they shared with you or did you ask to
12 review them before making that announcement?

13 **A.** No, it would have been unreasonable for me to have said
14 that I want to review seven different health board area
15 plans or potentially 22 local authority plans.

16 **Q.** Do you know if anybody reviewed them?

17 **A.** The health boards were due to review their plans.
18 They're supposed to have a framework of actions to
19 review and amend, and they'd been asked to review and
20 amend those in the preceding month. So the review of
21 those plans should already have taken place.

22 And actually, by the middle of March, the speed of
23 decision making and the progress of the pandemic is such
24 that -- your normal time frame in government for
25 reviewing things rapidly -- if you do something rapidly

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1 when they need to leave as well, and the risk when
2 people return to wherever their home is, including
3 a care home itself.

4 And I still think the framework of actions was based
5 on our best understanding of knowledge at the time, and
6 there are definitely strong social care voices within
7 the government when all of these conversations are
8 taking place. I know you're going to hear from
9 Mr Heaney later today.

10 **Q.** I was about to ask, who was the strong voice in those
11 discussions; would that have been Mr Heaney?

12 **A.** Yeah, he was the deputy director, so the number 2 in the
13 department. And, you know, we have a team of people
14 within the department. They're also in conversations
15 with Care Inspectorate Wales as well.

16 So there's always a demand for more people to be
17 involved in conversations. And in normal times you'd
18 have gone and talked to local authorities and the care
19 providers forum as well. The luxury of the time that
20 would take isn't available to us as we're going through
21 this.

22 **Q.** Can I move on now, please, to 8 April, and can we please
23 have on screen INQ000551798 at page 89. And this is an
24 extract from Albert Heaney's statement to this module,
25 and at paragraph 308 it says, and this in respect of

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1 within a month, that's pretty extraordinary. Actually,
2 a month is a very long time in the pandemic. And the
3 speed of decision making required means you have to make
4 choices.

5 So yes, it was my understanding, and that's what
6 this section of the -- this paragraph in my statement is
7 trying to get over: that even the pandemic flu plan,
8 people have been asked to review those in the preceding
9 months and amend those within the preceding months. So
10 by this point there should have been content about what
11 to do. The challenge is the scale of what's required
12 and the speed of what's required.

13 **Q.** Just finally then, please, on the framework of actions.

14 Looking back, do you think there was a strong enough
15 voice, or indeed any voice, in those discussions
16 representing the care sector as opposed to the hospital
17 sector?

18 **A.** The way the government works is, our health and social
19 services directorate is made up of health and social
20 care, so it's not simply an NHS department that has
21 social care tagged on. And it is about how you deal
22 with risk for the country, not just one sector of it, as
23 well. It's the point made earlier about the risk in
24 someone's home, the risk of someone in an ambulance at
25 the front door of a hospital, in a hospital, and then

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1 8 April:

2 "It was clear that if discharges were made,
3 hospitals would not be able to function effectively,
4 which would inevitably lead to increased deaths. In the
5 absence of advice to the contrary from health experts
6 ... and evidence regarding the possibility of
7 asymptomatic transmission, while testing of all patients
8 would have been preferred, without sufficient testing
9 capacity, it was not possible."

10 Do you agree with what Mr Heaney says there that at
11 this date, testing of all patients would have been
12 preferred?

13 **A.** In hindsight, yes, but this is a conversation -- I think
14 Mr Heaney is describing a conversation between officials
15 because certainly on 8 April no advice comes to me that
16 testing of all patients upon discharge will be
17 preferred, but there is not the capacity to do so. But
18 you expect your officials to have robust and honest
19 discussions, and I think the point is that if discharges
20 are not made, there will be increased deaths, and --

21 **Q.** Is there a possibility then --

22 **A.** -- there's an awful certainty about that, in addition to
23 not just deaths in hospital, but you'll find deaths for
24 people who don't make it into an NHS bed.

25 **Q.** Is there a possibility, then, that there was

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1 a conversation between officials about this, and that's
 2 something we can clarify with Mr Heaney?
 3 **A.** It's entirely possible. And ministers don't get to see
 4 every conversation officials have, but actually you
 5 expect officials to have robust conversations, and then
 6 to provide a view for ministers that either sets out
 7 areas of disagreement or areas of agreement for
 8 ministers to make decisions on, but I couldn't tell you
 9 the detail of that part of Mr Heaney's statement. I'm
 10 sure you'll take it up with him this afternoon.
 11 **Q.** That document can come down. Thank you.
 12 On 10 April you asked that a note be issued by the
 13 Chief Medical Officer for Wales to Care Forum Wales to
 14 provide clarity and reassurance around the testing of
 15 patients being discharged from hospitals into care
 16 homes. Why did you feel that that was something that
 17 was necessary?
 18 **A.** We'd had a letter I think on 8 April, Care Forum Wales
 19 had written to the First Minister, copied to myself and
 20 Julie Morgan, the Deputy Minister responsible for social
 21 care. And they'd expressed concern about the position.
 22 And the concern isn't irrational, you know, people are
 23 reasonably and rationally worried about what is
 24 happening, in every aspect of their lives.
 25 So Care Forum Wales, as the largest organisation of
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1 about testing figures?
 2 **A.** My recollection of this is that this relates to the
 3 testing of staff, as much as anyone else. So we had
 4 looked to create a system for frontline staff to be
 5 prioritised with testing, and one of the complaints at
 6 the time was that, I think it was 15 per local
 7 authority, was relatively low. In fact, we weren't
 8 seeing a take-up of all 15 of those tests, so I do
 9 recall that I was asked about this in one of the regular
 10 press conferences about what was happening.
 11 Having agreed to create a system to do that, because
 12 of the understandable priority for social care staff in
 13 particular, to not see that taken up was frustrating, so
 14 it's part of understanding, is this being taken up or is
 15 this a provision that is more than is required? And
 16 I think there were complaints about how easy the system
 17 was to use, but I expected the system to be used and
 18 maximised because that would then mean that if staff
 19 were concerned, they could isolate. And if they got
 20 a negative test they could return to the workplace with
 21 some confidence. And if the system isn't being used,
 22 then we need to understand why. So there's a bit of
 23 push and pull in doing this as well, and that's part of
 24 the overall, and you've seen, I think, my messages
 25 around this through April, around are we making best use
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1 private sector providers, are making representations
 2 directly saying, "We are concerned about this." So my
 3 request to the Chief Medical Officer is to provide
 4 reassurance about why the decisions are being made as
 5 they are, the underlying public health advice that goes
 6 into that advice, and to try to give as much reassurance
 7 as possible.
 8 It's both about the position on the state of
 9 knowledge at the time, but it's also that you need
 10 confidence for your system to function effectively,
 11 because if the system breaks down, you can guarantee
 12 that harm will be caused to both staff and potential
 13 patients or residents. I think social care refer to
 14 them as clients.
 15 **Q.** In an email from your Private Secretary on the same
 16 date, so 10 April, to Sir Frank Atherton and others, it
 17 was recorded that the ministers would like to receive
 18 daily or every other day updates from Data Wales on the
 19 testing numbers as a whole and broken down into health
 20 and social care. They realised there may be
 21 a confidentiality concern, but it should be easy to
 22 provide this information to both the minister and deputy
 23 minister on a daily basis.
 24 So by that date, on 10 April, do you consider that
 25 there was a gap in the data that you were receiving
 26

1 of the capacity we have, and is there a reluctance to
 2 use that capacity for reasons that aren't coming through
 3 to me?
 4 Because PPE is actually a bigger concern at this
 5 point in time, in terms of things that across my desk,
 6 but of course I'm aware of the challenge around testing
 7 and the need to increase it, because it's also a very
 8 difficult time in terms of our ability or inability to
 9 increase our testing resources more generally.
 10 **Q.** And we'll come on to that in a little bit more detail
 11 but just specifically in respect of the lack of data on
 12 testing, do you think that information should have been
 13 provided to you earlier than 10 April, if you're
 14 querying it at this point? Would it have been helpful?
 15 **A.** It would always be helpful to have more data in front of
 16 you than is useful, and it was because, and I recall
 17 there being a challenge around we're not getting enough
 18 tests. I thought we'd resolved that by having a system
 19 to have prioritised tests and, actually, the feedback
 20 was they weren't all being taken up. So I'd asked for
 21 the data so I could understand and see in front of me,
 22 are these tests being used, are they being maximised
 23 out, or is it a case that we're not getting people to
 24 use the system that we have to its best effect?
 25 **Q.** Now, at paragraph 109 you explain that:
 26

1 "Following the ministerial meeting [on 15
2 April 2020] Public Health Wales was informed that the
3 Chief Medical Officer for Wales and the Deputy Director
4 General, Health and Social Services wanted a revised
5 approach to testing to be put in place as soon as
6 possible, to include testing on hospital discharge ..."

7 You explain you sent an email the next day to
8 express your general concern that "at that point I did
9 not have clarity about why we had testing commitments
10 that we could not meet ..."

11 And you say:

12 "These issues included ... testing of care home
13 residents on release from hospital ..."

14 Putting aside capacity concerns for the moment, but
15 just dealing with the decision on 15 April, were you
16 a party to the decision to test all patients on
17 discharge, or was that taken by officials?

18 **A.** No, so paragraph 108 of my statement goes through the
19 discussion that took place between the first minister
20 and a range of ministers, definitely myself and the
21 Deputy Minister for Social Care. It's also the day that
22 the UK Government announced their plan for social care
23 and they say that they will test all patients before
24 discharge.

25 Now, we didn't receive advance notice of that or the

29

1 In the pandemic we are confident in April, remember,
2 we're having significant numbers of people testing
3 positive, more people coming into hospital needing the
4 provision that only an acute bed in the NHS can provide,
5 if your system breaks down at the back door your normal
6 risk and delayed discharges are even more significant,
7 and that's when you potentially get undignified care but
8 also the risk of an increased amount of mortality that
9 is potentially avoidable.

10 So maintaining confidence in the system is hugely
11 important.

12 **Q.** Can I just pause you there, Mr Gething. I understand
13 that's the reasons why the decision was taken, but it
14 doesn't seem, from the note of the ministerial meeting
15 on 15 April that the decision was actually taken in that
16 meeting, so can you help us with who actually took the
17 decision and whether you were involved in the taking of
18 the decision on that day?

19 **A.** No, I think that meeting gives a directive for officials
20 to go and look at changing the policy. So in 109, when
21 it says that Public Health Wales are told that the CMO
22 and the Deputy Director General want a revised approach,
23 that comes from the ministerial meeting. And I'm pretty
24 sure that Frank Atherton certainly is involved in that
25 meeting. I can't recollect because I haven't seen the

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1 basis upon which that was done, so you have these twin
2 challenges of: is the evidence base changing around
3 transmission and the ability to test? And, of course,
4 the evidence base around asymptomatic transmission is
5 changing all the time through April. Sorry, I'll try
6 and speak slower, I regularly get warnings about it.

7 As well as the evidence base changing, England then
8 have a significant intervention where they say, "We are
9 going to do this" and it's a surprise to us, and by this
10 point, particularly following the letter from Care Forum
11 Wales, and representations to the local authority
12 leaders, we're concerned that regardless of the evidence
13 on testing, we may not be able to maintain the
14 confidence needed for the system to keep on working.

15 If local authorities or significant care providers
16 say, "Look, we don't care what you say about the
17 evidence, we're just not doing this, we're too worried"
18 then, actually, that is the point at which you know your
19 system is breaking down, and you can guarantee harm will
20 come, harm to those people who need not to be in a
21 hospital, because a hospital, in normal times is the
22 right place to be when you're really ill, and it's very
23 quickly the wrong place to be, you can get
24 decommissioned and harm caused to you when you don't
25 need to be there.

30

1 notes but I would be surprised if Albert Heaney wasn't
2 also dialled into the meeting as well, but the direct
3 approach comes from the CMO and the Deputy Director, the
4 senior officer in the government on social care to
5 Public Health Wales, saying: we need to revise our
6 approach -- (overspeaking) --

7 **Q.** Would it be fair to say it was a ministerial decision,
8 then?

9 **A.** Yes, I think it is. And if you go back to the
10 concession the Welsh Government has made, it recognises
11 ministers made a decision and the guidance wasn't
12 provided until two weeks later, you know, a letter went
13 out a week later to care homes saying: this is what's
14 going to happen -- (overspeaking) --

15 **Q.** Can we explore that then -- sorry, Mr Gething.

16 **A.** Yes.

17 **Q.** Can we explore that then, please? Yes, as you say, the
18 decision was taken on 15 April and the subsequent
19 guidance was not published until 29 April. Do you
20 accept, along with the Welsh Government, that that was
21 a delay that simply shouldn't have happened?

22 **A.** Yes, it's part of the concession that I don't attempt to
23 walk away from. From the decision to the guidance going
24 out, I think it has to be accepted that the guidance
25 could have been provided earlier. And of course we

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1 wrote to care homes, wrote to the sector on 22 April,
2 that's not the same as having the guidance available.
3 So the practice started earlier than the guidance,
4 but the consistency and successful -- successfully
5 implementing the decision, having the guidance earlier,
6 would obviously have helped that. And I think it's
7 perfectly right and proper the concession has been made.

8 **Q.** Public Health Wales told the Inquiry that there would
9 have been capacity to implement that specific decision,
10 so testing all patients on discharge, from 15 April. Is
11 that something you're aware of, or can you disagree with
12 that in any way?

13 **A.** No, I wasn't aware that was the view of Public Health
14 Wales.

15 **Q.** And so in that respect, why did the Welsh Government
16 need to wait for guidance? Why could it not have
17 implemented the change from 15 April, given the
18 significance?

19 **A.** So once ministers make the decision, there's then the
20 conversation with Public Health Wales about being able
21 to do this. And, again, I know my statement refers to
22 the chronology in Albert Heaney's statement, the letter
23 that then went out on 22 April -- I understand Gillian
24 Baranski has confirmed this in her evidence last week --
25 that actually they were starting to see that there were

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1 and Northern Ireland. Do you say that this did in fact
2 cause a particular delay in Wales specifically?

3 **A.** Sorry, I don't understand the question.

4 **Q.** You explain that one of the reasons why there was
5 difficulty is that because the Welsh Government wasn't
6 aware that the English government was going to change
7 its position -- or that the UK Government was going to
8 change its position. And your quote is:

9 [As read] "It's one of the areas where there wasn't
10 the sharing of information you'd have expected between
11 Department of Health and others, but if the same
12 information had been shared with us, instead of being
13 announced, then I think we could have been in
14 a different position."

15 And so my question is: did the delay in the DoH
16 passing on that information actually lead to any delay
17 in Wales? Because both Scotland and Northern Ireland
18 were able to implement the policy quicker than Wales.

19 **A.** It's part about the -- the evidential base about the
20 science, the public health advice, about whether this is
21 the right thing to do, and it's also then about
22 confidence in your system as well, to maintain that
23 confidence.

24 If England were intending to do this, there wasn't
25 a sharing of scientific or public health advice, and

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1 tests being undertaken from a week later and the
2 challenge is about how quickly that can be done and
3 communicated.

4 If we'd simply announced on 15 April this is going
5 to happen, you're into the "where and which". If you
6 announce a decision and implement it afterwards, you
7 potentially have a more chaotic approach to it, and we
8 want the system to be ready and get on with
9 delivering it.

10 The concession is that actually, having made the
11 decision it should have been delivered earlier. So
12 I can't give an exact day about when that would have
13 happened and I can't tell you why Public Health Wales,
14 who don't actually operationalise all these decisions,
15 would be able to say that could have been dealt with on
16 a certain point in time. But I accept that it could
17 have been done earlier following the ministerial
18 decision and that's consistent with the concession
19 that's been made.

20 **Q.** I'm grateful, Mr Gething. You've touched on this before
21 and you say there wasn't the sharing of information
22 you'd have expected between the Department of Health and
23 others, and you've touched on the position in England on
24 15 April. But we're aware that there was earlier
25 testing of all patients on discharge in both Scotland

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1 "This is the justification for it", and I think we've
2 been through that before, it's part of the conversation
3 between health ministers as well. But if you're trying
4 to hold a -- if you're trying to hold a position that is
5 based on the evidence and then your neighbour with
6 a porous border goes the other way, then actually your
7 ability to maintain confidence is undermined. And you
8 can't be in a finger in the dyke position, because, as
9 I said, you know, the risk -- and's a real risk that is
10 on my mind throughout this particular part of the
11 crisis -- is, if we can't get people moving in and
12 around the health and social care system as they need
13 to, then we could have a northern Italy situation on our
14 hands and we could have lots of people dying who don't
15 need to.

16 So all of those things are in my mind. And, you
17 know, even if had been a conversation between officials
18 before they'd announced it, the day before, even the
19 morning when they were announcing it, we would have been
20 in a better position.

21 The earlier the information is shared, the earlier
22 we can take that into account, and of course, those
23 decisions do affect the choices we make for more than
24 one reason, as I've said.

25 **Q.** So would it be fair to say then that your evidence is it

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1 put Wales perhaps on the back foot but it's not the
2 reason why there was then the 14-day delay in Wales? Is
3 that a fair summary?

4 **A.** I think that is fair. I wouldn't try to say the
5 decision in England is the reason for the 14-day delay
6 from the ministers making decisions to the guidance
7 going out. That would certainly not be fair. But it is
8 fair to say that of course it put us on the back foot
9 and we could have been in a better position if we'd had
10 earlier notice.

11 **Q.** Reflecting, then, on the discharge policy, please, and
12 at paragraph 120 you refer to the 6 May 2020 SAGE
13 consensus statement on the association between the
14 discharge of patients from hospitals and Covid-19 in
15 care homes, and you say:

16 "... Covid-19 in care homes was not solely imported
17 from hospital."

18 Do you therefore accept that the discharge of
19 patients to care homes without a test did lead to at
20 least some cases of Covid-19 being introduced into care
21 homes?

22 **A.** Yeah, I think it would be impossible for me to say
23 otherwise, because what we now know and have much more
24 confidence on in asymptomatic transmission is, it's
25 entirely possible that that was a factor in Covid

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1 And I -- you know, I certainly don't want to try to
2 avoid that conclusion, because I think that has to be
3 right, doesn't it? It would be illogical to think
4 otherwise.

5 **Q.** The Inquiry has heard evidence about another route of
6 transmission into care homes, which was through the
7 movement of staff, particularly agency staff, those on
8 zero-hours contracts. Mr Hancock, when he gave evidence
9 to the Inquiry, discussed the significance of staff
10 movement, and said you could easily rejig the employment
11 arrangements to reduce staff movement.

12 Do you think the reduction of staff movement between
13 care homes was something that was desirable in Wales?
14 And reflecting back on your experiences over the
15 pandemic, are there any practical ways something like
16 that could be achieved?

17 **A.** Well, I think this is a real problem and a real factor.
18 People going into care homes are what changed the nature
19 of Covid in care homes. And, you know, the staff are
20 one of the factors.

21 That's not a criticism of staff, who made
22 extraordinary sacrifices, but if you've got people
23 working between three care homes, then it's much more
24 likely to be a factor.

25 We did go thorough this between health ministers and

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1 getting into some care homes, even if it wasn't the
2 dominant factor. And this is about understanding all of
3 your different risks, and how you try to address those,
4 both at the time and looking back.

5 Which is why, from your earlier questions and making
6 the point around if you can provide asymptomatic testing
7 to help with hospital discharge, there are good reasons
8 to do so, particularly given our experience of this
9 pandemic.

10 **Q.** Do you agree that -- I think you've just acknowledged
11 this -- the extent of how many cases were imported
12 thorough this route is difficult to determine
13 particularly in light of the lack of testing generally
14 in March and April? Is that fair?

15 **A.** I think it is difficult to determine. As part of the
16 SAGE consensus statement you referred to in
17 paragraph 120, Public Health Wales did a large study
18 looking at 3,000 discharges, and they come to the same
19 conclusion that the SAGE consensus statement does: that
20 you can't rule out it being a factor but you -- there
21 are a range of hospital -- homes that have hospital
22 discharges that don't have an outbreak. It's not the
23 sole factor. It's not the dominant factor. But I think
24 you'd have to accept that it is a factor in how Covid
25 got into some care homes in Wales.

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1 in calls. And part of the challenge, I think, is
2 I don't think it is as simple as just rejigging
3 employment being something that's easy to do. Actually
4 what you need to do is you need to do something about
5 sick pay and you need to do something about terms and
6 conditions within the sector more generally.

7 If you work three jobs in three different care
8 homes, it almost certainly isn't because you love
9 working in three different settings. It's about how you
10 make your wages up to be able to feed your family and
11 put a roof over your head. If the pay in care homes
12 doesn't mean you can do that in a single employment,
13 people will work more than one job. That's -- you know,
14 that's not, I think, contestable.

15 When you don't have sick pay, then actually part of
16 your problem is that you're giving people a perverse
17 incentive not to isolate, not to take themselves out.
18 But it's a -- I go through this in my statement in this
19 module and in Module 2B, it's a rational thing for
20 a person to do, to consider: do I go into work and
21 recognise that I won't be able to feed my family at the
22 end of the week, or do I not go into work and -- because
23 I'm worried about what might happen if I go in if I'm
24 not feeling a hundred per cent?

25 If you don't have reasonable levels of sick pay,

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1 then you understand why people make different choices.
 2 And it was part of our frustration in conversations with
 3 the UK, that we couldn't do something to actually
 4 deliver sick pay through the sector. And the challenge
 5 on wages is part of a longer-term reform I think the
 6 sector needs.

7 **Q.** Perhaps while we're on this topic, then, if we can move
 8 to funding. You confirm in your statement that as early
 9 as March you had received correspondence from trade
 10 unions drawing your attention to the fact that those who
 11 worked in social care who were required to self-isolate
 12 or who fell ill would only receive Statutory Sick Pay
 13 and so would not be able to afford to take time off
 14 work. And I think this is something you say had your
 15 sympathies from early on in the pandemic; is that right?

16 **A.** That's correct.

17 **Q.** You outline in your statement and the Inquiry has heard
 18 evidence that the UK Government announced the infection
 19 control fund in May 2020, and part of the purpose of the
 20 fund was to ensure that staff who were isolating
 21 received their normal wages while doing so. And in
 22 fact, in Wales, it was recommended in the '*Black, Asian
 23 and Minority Ethnic COVID-19 socioeconomic
 24 subgroup: report*' that thought should be given to
 25 funding, particularly for those who needed to isolate in

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1 would be changed later in the year and we would find
 2 ourselves not able to meet the commitments that we
 3 wanted to make.

4 So it's a real point of unhappiness and frustration
 5 that we weren't able to do this earlier. If we'd had
 6 greater certainty on funding and that the funding
 7 wouldn't be clawed back, we could have acted earlier.

8 **LADY HALLETT:** Mr Gething, I'm sorry to interrupt, but
 9 Ms Paisley's question was carefully phrased. The
 10 Statutory Sick Pay scheme in Wales didn't come in until
 11 November 2020, later than the other parts of the
 12 United Kingdom, including the other two devolved
 13 nations, all of whom are subject to the same kind of
 14 challenges you have just described.

15 So could you please now try to address why the Welsh
 16 scheme came in later than Northern Ireland or Scotland
 17 and England.

18 **A.** Yes, there's still a level of caution. It's about how
 19 quickly we're able to move with the work that's being
 20 done in Wales. I think it is fair to say that I would
 21 have liked that scheme to have come in much earlier, and
 22 the conversations that we're having with the whole
 23 sector. So yeah, I think it's reasonable to say
 24 that I would definitely have wanted that scheme to have
 25 come in earlier than it did.

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1 the social care sector.

2 However, as you've told the Inquiry in your
 3 evidence, the [Covid-19] Statutory Sick Pay Enhancement
 4 Scheme in Wales did not come in until November 2020, and
 5 this was later than all other parts of the UK had
 6 addressed this issue.

7 Now, I appreciate you cover this in your statement
 8 in your written evidence, but can you please explain why
 9 it was that this scheme came in later in Wales, please.

10 **A.** Because of the uncertainty around what happens with
 11 Barnett consequentials.

12 So an announcement is made in England, we're told
 13 roughly there'll be a consequential, but that
 14 consequential can change later in the year. So you
 15 don't have all the financial certainty to make choices.
 16 That is a real factor.

17 It's also, I think, linked to the suggestion about
 18 an additional payment for social care workers as well.
 19 Now, the level of certainty that we needed to be able to
 20 make the choice on sick pay wasn't there until later in
 21 the year, and I go through in my statement about the
 22 range of funding pressures that were available. I would
 23 have liked us to have been in a position to have
 24 confirmed the position on sick pay earlier, but there
 25 was a level of real caution and concern that our budgets

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1 We couldn't do it immediately, when the announcement
 2 was made in England, and that caution around trying to
 3 understand where is the realistic level of possibility
 4 that this money can be clawed back, and when do we have
 5 certainty to go ahead and deliver the scheme, as well?

6 **MS PAISLEY:** Can I ask, were there conversations with
 7 Scottish and Northern Ireland ministers, or indeed
 8 between officials, to ask how it was that Scotland and
 9 Northern Ireland had found a way through these problems,
 10 and if there wasn't, would that have helped?

11 **A.** I think our officials did have conversations with
 12 counterparts in Scotland in particular, but the
 13 officials working on that were the -- having those
 14 conversations with officials working on the scheme in
 15 Wales as well and having conversations with stakeholders
 16 in the sector.

17 **Q.** Given the significance of this matter, in the event of
 18 a future pandemic, how could such a scheme be introduced
 19 quicker?

20 **A.** It's one of the points that I've made in I think
 21 Module 2 as well as this one, that actually addressing
 22 Statutory Sick Pay in the care sector -- if it isn't
 23 already addressed, the permanent part of terms and
 24 conditions, then addressing this early in a future
 25 pandemic would be important, because you're allowing

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1 people to make the right choice without having to factor
2 in their own personal circumstances in a way that
3 I think it's credible did take place in this pandemic.
4 So the earlier and the more certainty, the better.

5 And you could simply have a UK scheme that ensures
6 that this is being delivered, because you could then
7 make sure that it adds up with the tax and benefits
8 system, of course. The benefits -- (overspeaking) --

9 **Q.** So would your evidence then be that the UK scheme would
10 be the way to address the delay?

11 **A.** I think you need the four nations of the UK to have
12 a grown-up conversation about how to do this, and then
13 for the Inquiry to make the recommendation that this
14 should be addressed, whether it's by an individual UK
15 scheme or by the four governments working together to
16 make sure that the way that this service is organised
17 (unclear) the four nations is able to do this, then you
18 can have UK-wide consistency, which I think is the
19 objective that should be high on the priority list for
20 a future pandemic.

21 Obviously it's a matter for the Inquiry to decide
22 what recommendations it wishes to make.

23 **Q.** Finally, please, on funding, in Wales the Carers Support
24 Fund was introduced and funding was provided to unpaid
25 carers. Is it your view that that fund achieved its aim

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1 **Q.** Thank you. And I think this is something you covered in
2 quite a bit of detail in your statement so I don't have
3 any more questions about that, but can I return, please,
4 to May 2020, and I'm going to return to developments in
5 testing.

6 Can we have on screen, please, INQ000327582_0016.

7 This is an entry you made in your notebook, and we
8 can't see the date on this page but it's 5 May 2020, and
9 from the initials we can see -- perhaps if we can zoom
10 out just to see a little bit more of the page.

11 We can see the initials JF, RS and MH -- thank
12 you -- and so can we deduce that this was a four nations
13 health ministers meeting on the basis of those initials?

14 **A.** Correct. RS is Robin Swann, MH is Matt Hancock, JF is
15 Jeane Freeman.

16 **Q.** Thank you.

17 Now, you write next to your initials, VG, so I think
18 we can take it that this is something you raised in the
19 meeting:

20 "science on testing in care homes; not seen added
21 evidence. Advice to test in every care home. Would
22 want that shared if it exists, ideally with CMOs."

23 It then says:

24 "MH [which I take to be Matt Hancock] --
25 CMO England, advised him to test across care homes --

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1 and that sufficient funding was provided through that?

2 **A.** It's my understanding because we had the approach from
3 the relevant carers organisation in Wales, who said that
4 they could administer a fund directly to unpaid carers,
5 because they were -- they're the main support group for
6 those carers, they understand who they are and how to
7 administer the fund in a way that is efficient and
8 rapid. And, you know, we did make changes to the scheme
9 that we had, where there were -- I think I cover this in
10 my statement -- when there was additional demand in
11 different parts of the country, we were able to shift
12 money around.

13 Obviously, understanding from people who were unpaid
14 carers what a future pandemic might look like, not just
15 with PPE, but the practical support that they would
16 need, monies passed that -- for some of them, not for
17 all of them, and understanding how you deliver that.
18 I think it's hard to deliver a single scheme that
19 doesn't have elements of discretion in it, but actually
20 I think that the answer we came up with in not using the
21 discretionary assistance fund was the right one to do,
22 because you wouldn't expect unpaid carers to engage in
23 a fund they may never had heard of, and never had
24 interaction with, whereas they were familiar with the
25 carers organisation that we partnered with.

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1 advice updated within last week."

2 And it then says:

3 "VG -- not shared with CMO Wales and obvious
4 difference to test whole sector as opposed to test homes
5 with symptomatic or confirmed cases."

6 Firstly, following this meeting, are you aware as to
7 whether the advice Mr Hancock had received was in fact
8 shared with Sir Frank Atherton?

9 **A.** No, my understanding is that there was no additional
10 advice note that was shared between CMOs. Frank
11 Atherton was particularly exercised and unhappy about
12 it. I think it's best to be polite about the level of
13 his unhappiness.

14 **Q.** So would it have been helpful if these advice notes were
15 in existence and might be applicable across the four
16 nations for such evidence to be shared as quickly as
17 possible?

18 **A.** Of course, and you'll see the next note, Robin Swann and
19 Jeane Freeman agreed, and the advice should be shared
20 between chief medical officers who were meeting that
21 evening. But my understanding is there was no advice
22 note that was shared, and I don't think it's the sort of
23 thing that Sir Frank Atherton would have kept secret to
24 himself.

25 **Q.** No.

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1 A. This was a highly pressurised environment, highly
 2 contested with lots of attention and it's frustrating
 3 even now looking back -- because I remember where I was
 4 taking these calls and everything that was happening at
 5 the time, and it really would have been helpful for all
 6 of us if that advice existed, for it to have been shared
 7 with all chief medical officers.

8 Q. Did Mr Hancock offer any reason as to why such
 9 significant evidence wasn't being shared that you can
 10 recall? Or he didn't know either?

11 A. No, he said, "My CMOs advised me." And that was it. It
 12 wasn't that "I got this note and I'll send it to you
 13 myself".

14 Q. I'm grateful. That document can come down, thank you.
 15 On 2 May 2020 you had issued a statement in Wales in
 16 which you noted that at that point the scientific advice
 17 did not support blanket testing. Fast forward, then, to
 18 this meeting on 5 May. Did you question the scientific
 19 advice you were in receipt of, if it appeared the
 20 UK Government had access to different advice?

21 A. That's the whole point, isn't it? It's about going back
 22 and saying, "I've had this call, this is what's going
 23 on, is there an advice note?" And there's a fairly,
 24 like I said, a fairly lively and exercised conversation
 25 between officials including the Chief Medical Officer

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1 you said:

2 [As read] "I know there are -- somebody said we
 3 should have been testing asymptotically at a much
 4 earlier point, but at that point the advice and the
 5 evidence wasn't there to test asymptotically. If we
 6 had had that evidence we would have had a very practical
 7 challenge of how to prioritise the tests, so even if
 8 we'd had that advice at a much earlier stage, we would
 9 still have had to prioritise about who we were testing
 10 and why."

11 And you referenced, in response to some questions,
 12 a statement made by Mr Drakeford in the Senedd Chamber
 13 and you said:

14 [As read] "The nuance or cut and thrust of the
 15 debating chamber doesn't always translate well into
 16 having a more forensic examination of it. Mr Drakeford,
 17 the First Minister at the time, was setting out that the
 18 advice doesn't say that we should do this."

19 And so can I please just clarify, do you accept that
 20 prior to 6 May 2020, the Welsh Government had received
 21 at least some advice that there was value in
 22 asymptomatic testing for care homes, and as one of those
 23 examples, there was a 1 May ministerial advice and you
 24 deal with that in your statement at 113 to 114.

25 A. Yes, so I'm setting out that we've had advice in that MA

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1 about saying, "No, there is no additional advice that we
 2 have received."

3 So you need to be able to trust each other to work
 4 together and to share information, and this was a really
 5 good example. And where that isn't done, you used
 6 a good deal of time, energy and effort from your senior
 7 decision makers and advisers in chasing something that
 8 doesn't appear to exist or isn't being shared. And so
 9 you're still reliant on: well, here is the evidence and
 10 advice that we have. And I don't think a brief
 11 disclosure in a four-nation health ministers call is
 12 a sound basis to upend the advice that you're working on
 13 and the evidence you have.

14 I don't understand why, if that advice existed, why
 15 it wasn't shared at the time, why it wasn't shared
 16 between CMOs. But again, it's another pebble in the
 17 pond that has a real practical impact in terms of public
 18 confidence around what is being done at the time.

19 Q. Can I please touch, again, on some evidence that you
 20 gave in Module 7, again with the further focus on the
 21 issues being explored in this module. And you were
 22 asked in Module 7 about the decision to extend
 23 asymptomatic testing to all care homes which was
 24 announced on 16 May 2020, and that was an update on
 25 a former announcement that had been made in May. And

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1 that sets out the range of certainty and uncertainty
 2 that exists around asymptomatic testing. We had
 3 previously moved on treating an individual case as an
 4 outbreak in a care home, and so you go and try and deal
 5 with all residents, at that time, and staff. So we'd
 6 had a fairly significant amount of coverage for care
 7 homes affected, and that then means that you are testing
 8 asymptomatic residents where there has been a positive
 9 case in a care home.

10 My point around the point in the debating chamber is
 11 that there are times you respond when actually, if you
 12 were reflecting and providing a written response, you
 13 probably wouldn't use all the same words that are used
 14 in the chamber. You know, people do misspeak from time
 15 to time. The advice that I'd received is as has been
 16 disclosed to the Inquiry, and that's the advice I was
 17 dealing with and making decisions from.

18 Q. Thank you.

19 Can you please confirm, then, was the reason that
 20 asymptomatic testing for all care homes not introduced
 21 prior to 16 May because the evidence and advice received
 22 didn't support asymptomatic testing generally, or was it
 23 because at that stage, the advice in light of capacity
 24 meant that that shouldn't be prioritised at that stage?

25 A. No, it's that at that point in time, the evidence

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doesn't support general asymptomatic testing. We've moved on testing residents where there is a Covid case in a care home, but we're not testing everyone where there is no Covid case in a care home from staff or residents. So that's the advice on whether this is the right thing to do in, if you like, scientific and public health terms.

Actually, though, I'm trying to recognise in my evidence to the Inquiry that if that were the advice at that time, it would require a significant increase in tests. I think the advice note you're referring to talked about 25,000 tests being needed to do so, and the scale-up of that kind in the programme isn't there, and if we announce that we're going to do it, we should be able to deliver it.

And if we'd announced we're going to do that on the next day, then we would have been able to do it on the next day, we needed to scale up our ability to get tests to people and to get them back. So, you know, when England then made other announcements, I think the announcements said they were going to do everything. In fact they'd agreed a prioritised rollout of testing, as well.

Q. So I think --

A. So that's the -- that's the way in which I made choices.

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do it.

Q. And in Module 7 on that section of your evidence you ended it by saying, "With the knowledge we have now, we would make different choices. And I think it's important to acknowledge that."

So I appreciate these are views with hindsight, but what choices, even with hindsight, may have been different so that we can learn from them for a future response?

A. So with hindsight, both on the hospital discharge, with hindsight, I think it's the point you made earlier about testing there, there's then the point about whether you have -- when and how you introduce surveillance testing in care homes, that's asymptomatic testing with or without a case being available, and also then stratifying where higher risk homes are, and most of the evidence suggests that larger care homes with larger movements of people in and out of them, which is inevitable, are a higher risk, and so if you had to stratify where to start that testing, you'd start with your larger homes and homes that had positive cases within them.

So how you would prioritise that would be, regardless of your resource, I think it's fair to say that you would bump up the list, the opportunity to have

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Q. Is this, then, the distinction: because you were being advised that you would need 25,000 more tests so you would need a lot more capacity, but the advice note on 1 May, and it made reference to the Easter 6 study in Public Health England, do you not agree that that advice note made it plain that there was value but you'd need 25,000 more tests to do it? That is the distinction I'm wondering about.

A. Yeah, no, it -- from earlier in the pandemic where the advice is much clearer: look, this isn't really a high-value use of the tests. The advice on asymptomatic transmission is shifting, and through April it shifts quite a lot, actually. And so there's a recognition that there would be some value in asymptomatic testing at that point. It's part of the reason why we'd moved on where there were Covid cases in care homes to then test the rest of the residents, as well, because of that recognition. And it is still then, though, the advice is still set out in the advice not, the public health and scientific advice at that point doesn't support testing every care home on a regular asymptomatic basis.

It doesn't mean there's no value in doing it, but it doesn't support taking that choice, but if you wanted to do that, then you would need significantly more tests to

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some form of surveillance testing within closed settings, which care homes are an obvious one.

Q. Can I briefly then touch upon testing capacity. And it's right that you challenged underuse of testing capacity a number of times with those advising you, and you go through this in some detail in your statement, and you sent an email on 16 April, and you noted "My concern that I was the public face for the Covid-19 testing strategy and responsible for explaining matters to the public", and we touched on this email earlier. You said:

[As read] "At this point I had not been clearly told why we had commitments that we could not meet and I did not have a sustainable position to offer on increasing capacity and usage, apart from repeating my very real frustration that we were not maximising use of capacity that we had."

Now, in your Module 7 statement you explain when you challenged this you were told by officials that there were three main reasons why maximum capacity could not be used at this time, and to paraphrase, you were told: firstly, we could not plan to use it all as some flexibility was needed; secondly, we were not able to run and maintain the equipment at full tilt, and confirm how long it would reliably run; thirdly was, of course,

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laboratory capacity.

And if we can please have on screen INQ000530780, and I'm close to finishing this topical with you, Mr Gething, just couple more questions, please.

Now, at page 3, the daily figure of tests that could be undertaken was 2,100 and we can see on this date, 4 May, only 892 tests were used, and then scrolling up, on 5 May we can see that 743 tests were used, and again, this was dealt with briefly in Module 7 and you said you continued to challenge it. Specifically in respect of what this meant to the adult social care sector, do you feel that you sufficiently challenged why some of these under-used tests could not be redirected to the care sector that so desperately needed it?

A. I don't think that my challenge and questioning in writing and in conversation with officials could be anything less than pointed and robust, but the challenge always is about making sure that as a minister you're properly equipped with information about what's happening, and then able to challenge and redirect where required.

So the explanations provided to me were rational around the number of tests, the number of purposes, but there wasn't, then, an explanation about "You need to have this number or proportion of tests available to

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capacity to allocate anywhere else beyond our priorities. But I still had the -- I forget the date of the tests you showed me, forgive me, counsel, but it still goes back into the evidence we had at the time about where and how to deploy your tests regards how many you have them. So it's by this point --

Q. 4 and 5 May.

A. By this point I think we'd had I think the ability to use the tests, not just in the social care sector, but if we'd had more tests we probably would have used more tests, I think. But that's also why I'm concerned that the figure is 740 and this time, you know, just over a third of our available testing capacity is being used. I need to know, of that nearly two-thirds, do we need to maintain a third of it for other NHS uses? Do we need to maintain half of it? I then have an understanding, or would have an understanding, of how much capacity we could reasonably use on a regular basis in Covid testing, and where and how that could be prioritised. That may not be used fully on every individual day, but I'd have a better idea about how those tests could be used, and that's the point I was trying to make in the conversations I was having, as well as in the emails I was sending, because I need to go out and explain the position, which is contested because we had a testing

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undertake these other functions within the health service, and here's the assessment on the amount of reasonable running capacity." Because the problem is that then -- my frustration, I explained it, was, that number of 2,100 isn't real then, is it? Because actually, if that's running at full tilt, well, actually, what is the reasonable, regular run rate that you could actually have? And we'd be better off saying that rather than the theoretical number than I'm then advised if we carried on doing that, would make our system fall over.

So it's not helpful, I found, to have a number that isn't achievable and then a significant under-utilisation of that maximum number without there being an explanation as to why. And actually, some of this is difficult to go out and explain, it says this but there's a reason why we're not doing that, but at least I'm equipped to make choices about how to explain that to the public. The bigger issue is actually our inability to scale up the testing programme.

Q. And is it your evidence then at this point more tests could and should have been allocated to the care sector, or is your evidence that it wasn't possible at this time?

A. Well, at this time, I wasn't aware that we had extra

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plan that envisaged us being able to significantly increase our testing capacity, that we'd not been able to meet.

And the Roche element of that was only one element of it. As we then -- it suddenly came out that, actually, there were things we couldn't say in public, about equipment that had been held up in different parts of the world, as well, that when it arrived, did allow us to increase the Public Health Wales laboratory testing capacity that we had independent of Lighthouse Labs.

MS PAISLEY: Thank you, Mr Gething.

I wonder if, my Lady, now is good time to take a short break.

LADY HALLETT: Definitely, Ms Paisley. I shall return at 11.35.

MS PAISLEY: Thank you.

(11.19 am)

(A short break)

(11.37 am)

LADY HALLETT: Ms Paisley.

MS PAISLEY: Thank you, my Lady. I'm just waiting for everyone to appear on the screen.

LADY HALLETT: Mr Gething is there for me. Is he there for you?

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1 **MS PAISLEY:** Not yet.

2 **LADY HALLETT:** Am I?

3 **MS PAISLEY:** No.

4 Ah, my Lady, you are now there. I'm just waiting on
5 Mr Gething.

6 **THE WITNESS:** I'm definitely here.

7 **MS PAISLEY:** I'm grateful. I can see you now, Mr Gething,
8 thank you.

9 Just two more short questions on testing, please.

10 On 23 November 2020 you agreed that domiciliary care
11 workers should be included in the asymptomatic testing
12 programme for frontline health workers. Do you think
13 that they should have been introduced in that programme
14 earlier, please?

15 **A.** We had literally just introduced the asymptomatic
16 testing programme for health workers, and that was on
17 the basis of having lateral flow devices available. So
18 we trialled those. It's possible we could have
19 introduced it a day or two earlier, I won't demur from
20 that, but it was about the same time frames. There
21 wasn't a giant time lag compared to health workers.

22 **Q.** When the programme of routine asymptomatic testing was
23 put in place, how were you provided assurances in
24 regards to both residential care and domiciliary care
25 that that testing was in fact taking place?

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1 UK Government, did not impose vaccination as a condition
2 of deployment in the care sector. Can you please
3 briefly explain the main reason the Welsh Government
4 took that decision and whether you think it was the
5 right decision?

6 **A.** I think it was the right decision, because our
7 vaccination programme had been successful in reaching
8 a much higher number, well above the minimum levels of
9 percentage vaccination that SAGE recommended was
10 required. So we were comfortably above both of the
11 markers that SAGE had set. So it wasn't a factor for us
12 to consider. If vaccination as a condition of
13 deployment had been introduced then we potentially could
14 have lost some of our staff, as well.

15 England had a different challenge. We were in
16 a different position because of the relative success and
17 speed of our own vaccination programme.

18 **Q.** The next topic, please, is DNACPR decisions. Was it
19 ever the intention of the Welsh Government that any of
20 its decisions or policies should lead to the
21 implementation of blanket DNACPR decisions?

22 **A.** No, that was never our intention. In fact, that was
23 clarified on more than one occasion, both when an
24 incident did arise around a general practice in Bridgend
25 that I've covered in my previous evidence; also from the

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1 **A.** So we did have problems, so, so the asymptomatic
2 programmes that were introduced, so the regular testing
3 in care homes, we initially had weekly testing in care
4 homes, and that led to two-weekly and then actually
5 Covid rates started to rise, so that changed. It was
6 delivered through Lighthouse labs and the portal of
7 delivery.

8 Now, we did have challenges on the delivery of that
9 and I think I cover it in my evidence, in September at
10 some point, myself and Jeane Freeman wrote to Matt
11 Hancock and I think it's common ground that there were
12 problems with Lighthouse labs at some point, they
13 couldn't cope with the volume of tests, and that
14 actually some of the tests had to be redone because the
15 swabs weren't -- you couldn't use them to test because
16 the delay from taking the swabs to actually testing them
17 was too great.

18 So I think I cover this in my statement as well, and
19 in previous evidence about needing to re-maintain
20 confidence, we managed to flex some of our resource
21 available from the increased availability of Public
22 Health Wales lab tests at that time, as well.

23 **Q.** Thank you. Three shorter topics, please. The first of
24 those is vaccination as a condition of deployment.

25 Now, the Welsh Government, in contrast to the

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1 ethics group, and, indeed, I think two pieces of
2 correspondence that went out from the Chief Medical
3 Officer and the Chief Nurse reiterating that they had to
4 be individual and informed discussions and decisions and
5 that age, disability or other factors were not to be
6 used to justify blanket imposition of DNACPRs, which did
7 not happen in Wales, as far as I'm aware, but there was
8 concern about it.

9 **Q.** Now, the Inquiry's Every Story Matters received
10 evidence, and a care home worker in Wales said, "Our
11 local doctor put a blanket DNACPR on all his patients to
12 stop them taking up beds in the hospitals, which
13 families contested." So were those matters ever brought
14 to your attention, that there was some evidence it was
15 taking place?

16 **A.** So we had one incident that I cover in my evidence.
17 I don't know if the Every Story Matters covers the same
18 issue, but it sounds similar. And when that was brought
19 to my attention we acted quickly, my officials got in
20 touch with the practice, they reversed the position
21 they'd taken, and that led to a broader system-wide
22 reminder of the fact that DNACPRs should not be used on
23 a blanket basis.

24 Beyond that one incident, no other incidents were
25 brought to my attention, but because of the concern that

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1 existed, as I said, we did issue a further system-wide
2 reminder on the appropriate and inappropriate use of
3 DNACPRs.

4 **Q.** And the third of my briefer topics, please, is the
5 regulatory inspection regime, and a number of Core
6 Participants, including in their corporate statement the
7 Covid Bereaved Families for Justice Cymru, they've
8 raised concerns about the suspension and general
9 reduction of regulatory inspections over the course of
10 the pandemic and their concern is that without
11 regulatory oversight it's difficult to know whether
12 their loved ones were provided with proper care.

13 How were you assured about the care being provided
14 in Wales in the absence of inspections?

15 **A.** So there was remote interface between Care Inspectorate
16 Wales and care homes. I think Gillian Baranski has
17 covered this in her evidence.

18 It's also important to reflect, though, that
19 reducing the number of visits to care homes was an
20 important factor in trying to minimise the risk of Covid
21 getting into care homes in the first place. I think it
22 would have been pretty unusual to have a couple of
23 inspectors turn up in the middle of April saying they
24 wanted to undertake a normal inspection for a home that
25 was undertaking tasks that were anything but normal.

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1 Services at present, would be a sensible thing to do.
2 And it was, overall, a successful story. And that's
3 also the view of Audit Wales as well.

4 **Q.** Can I please ask about some of the specifics.

5 So, on 19 March 2020, you issued the written
6 statement to announce that the NHS Wales Shared Services
7 Partnership's remit would be extended to secure and
8 supply PPE to social care settings in Wales.

9 Now, the announcement also explained that if PPE
10 could not be accessed while the partnership prepared
11 itself to distribute stock to local authorities,
12 arrangements had been made that care providers could
13 approach local health boards for urgent assistance.
14 What were the practical preparations that had to be
15 made?

16 **A.** Well, every care home has a relationship with its local
17 NHS, so it's not as if this was an entirely unknown
18 relationship that exists. The practical circumstances
19 were having -- giving instructions for the pandemic
20 stocks to be released. We'd then need to replenish them
21 and resupply them. And it's about giving confidence to
22 people, because some care homes, having their own
23 established supplies that have collapsed, were genuinely
24 concerned. They talked to colleague care home
25 providers, they talked to the local authority and they

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1 But it's one of those uncomfortable realities of
2 managing the risk means you take decisions you wouldn't
3 normally take in normal times.

4 I think it was the right thing to do but I recognise
5 that that is -- that does not -- come with downsides for
6 people seeking assurance, but the remote contact was
7 part of what we were looking at. And of course care
8 homes were regularly in contact with us and other
9 stakeholders because of the nature of the pandemic and
10 the guidance. There was a regular stream of contact.
11 It wasn't as if care homes were left to their own
12 devices to do what they wanted when they wanted.

13 **Q.** Can I then, please, move on to personal protective
14 equipment for the care sector.

15 Now, in Module 5, Andrew Slade told the Inquiry:

16 "And I think we've already said, as a government,
17 that in a future pandemic we would immediately move to
18 involving provision for care settings into the work of
19 the Shared Services Partnership."

20 Is that something you agree with and support as
21 well?

22 **A.** Yeah, I think I've said in my own evidence that Shared
23 Services was a success, and if you had the same
24 situation, where supply lines collapsed, that, actually,
25 moving to a central purchasing service, which is Shared

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1 talked to the health service as well.

2 So the state was reiterating that if the health
3 board has supply, care homes should approach their
4 health board. And that would -- and they could do that
5 through their general practitioner, through the care --
6 through the health board, where they will all have
7 contacts with their health board, seeking assurance
8 around the supply of items. And that obviously depends
9 on what the items are then as well.

10 **Q.** Could we then have on screen INQ000349300, page 4.

11 Which is an email you sent to various officials on
12 3 April 2020, and this had followed a meeting with
13 council leaders, and you explain in that email:

14 "I will want an update on how our current stocks are
15 being used and how much we have left as soon as we have
16 anything useful about the actual demand and need across
17 health and social care."

18 Was there then limited information reaching you
19 about stock levels and how much was needed across the
20 sector?

21 **A.** Yes, so I wanted to have -- and I did then get --
22 a regular understanding of the amount of stock. But the
23 problem is, having a figure of X hundred thousand or
24 X million items isn't particularly helpful, because you
25 need to understand the burn rate, the use rate of those

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items. And we did then eventually get more granular detail on the number of days of supply we had left for each of the items. And I'm sure we've disclosed to the Inquiry an example of how that was provided.

It's also about the level of demand, and that's really important, because demand and need across the sector were different in different places. Some providers will have more stocks available to them. Not everyone's supply line had collapsed by this point. But it is understanding: where that's a challenge, how do you then meet it?

And, you know, every sector outside the NHS is always a bit concerned that: is the NHS being prioritised over and above us? And are we really being listened to?

And council leaders, as you'd expect, were raising that issue. And I know one of them is mentioned in this email. So it was important to not just be sensitive to that concern but to want to get some reassurance about the level of supply we have and how that's being used. That's why we changed from the published information on the amount of supplies we were giving out, to be clear about the level of supplies that were going into social care as well.

Q. And going into, you know, the possibility of a future

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to maintain confidence across the health and social care sector. And I think when that was published it was welcomed not just by them but also by trade unions as well.

Q. Just a few more questions, please, on this email chain. You received advice from Chris Jones, and on page 3 he said:

"The risk to care workers in care homes and other close communities is likely to be less than in hospital settings since residents are self-isolating and visitors are banned."

However, as we've discussed, expedited discharge at this stage was already taking place.

So did you accept the advice that the risk to care homes was less than hospitals?

A. Yes, because some hospital settings plainly do have a higher risk level to them. If you're dealing with acutely well -- acutely unwell people, then that is a different level of risk to care homes. It does not mean there is no risk in a care home. Far from it. That depends on the tasks that are being undertaken as well, but it is about how you stratify and prioritise.

Even within the NHS, even within a hospital, there will be different levels of risk depending on the task you're doing. A hospital porter has a level of risk,

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pandemic, is that the minister who has responsibility for this having access to that data is something that should be available as early as possible?

A. Yes, it would be helpful. I think Alan Brace gave evidence on this in Module 5. He was really helpful in getting to grips with what was happening within the system, and in the making sure that we had a proper understanding of the usage rate, the amount of stock that we then had for the use at that time -- because our pandemic stocks had been created on the basis there should be six months' supply, and given in a previous answer I think we went through them in half that time. So we didn't have six months' space to get this sorted out at all. So understanding, not just that you have the stock you have built up, but in the pandemic you're facing how quickly can you understand the amount of stock you've got, how long that will last, how many days of supply have you got, and are you then supplying just the health sector or are you then having to take on social care supply as well?

And also the clarity of not receiving the information that comes to the ministers, but on -- I think it's important that you have a way of publishing and making available publicly what you're doing on that as well, because that is one of the things that can help

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but actually that won't necessarily be the same as someone who is in a theatre or dealing or working in an emergency department with acutely unwell people as well. So it's trying to understand the risk for the task that someone is undertaking.

And this is a general point around what takes place in a hospital setting compared to a residential home, but it doesn't mean that there's no risk. Far from it.

Q. The advice also said the risk to care workers in the community who are visiting people who are being shielded or who are in self-isolation is also low, provided they observe guidance on hand washing.

However, at paragraph 1 of that response, on page 2, it's confirmed that community transmission was occurring across Wales and the UK. So domiciliary care workers may themselves then have been exposed to the virus, and indeed perhaps many of their clients. So do you think you accepted that advice at that stage?

A. You know, this was the advice from the Deputy Chief Medical Officer, but it's on the basis that you're able to successfully implement the measures that are set out.

Now, if you're going into someone's home and undertaking personal care tasks, your risk shifts, doesn't it? That's natural. But it depends on the tasks you're undertaking and whether you can

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1 successfully undertake the tasks that he refers to. Can
2 you socially distance? Do you need to hand wash? Have
3 you got the appropriate PPE? And that is the point
4 around the relative level of risk.

5 And again, this all tiered, depending on the tasks
6 you're undertaking and the jobs you're doing, rather
7 than "care workers are low risk, healthcare workers are
8 high risk". That sort of crude description isn't what
9 this guidance is trying to set out.

10 **Q.** In the event of a future pandemic with similar
11 characteristics, is there anything that can be learned
12 surrounding the provision of PPE for the care sector
13 when community transmission is known to be occurring?

14 **A.** Yes, I think some of this comes back to what we know
15 about this pandemic and the changing evidence basis
16 around a range of control measures. So if you can
17 undertake social distancing, that is a control measure
18 that protects you and the person you're potentially
19 undertaking tasks for. If you can't do that, then in
20 particular, the changing nature of what we're able to do
21 on face masks, I mean, fluid resistant ones would be
22 important, as well. The points around ventilation, to
23 ensure that if it's possible to be in a well-ventilated
24 setting, that reduces the risks for everyone who is
25 undertaking those tasks, as well.

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1 people went out and had a drink, and there were regular
2 reports of social distancing disappearing after the
3 second or third drink. There was lots of concern that
4 that would lead to a spike in Covid in another three
5 weeks' time.

6 Part of the reason why that didn't happen is, that,
7 actually, when people were drinking outside then,
8 actually, you're much more protected than being in an
9 indoor setting, as well, so our understanding of the
10 benefit of ventilation shifted significantly through
11 a period of months.

12 Having well-ventilated spaces in care homes, either
13 for visiting pods outside the normal care home or how to
14 facilitate indoor visits, our understanding has shifted
15 significantly.

16 A similar pandemic, we could undertake different
17 measures at a much earlier point that would enable
18 low-risk contact with people, whether that's for care
19 or, indeed, for visits.

20 **Q.** Two more questions, please, on PPE. By 7 May 2020,
21 which was seven weeks after your written statement on
22 19 March that we have looked at, two-thirds of the
23 social care sector's PPE needs were being met by the
24 NHS Shared Services Partnership arrangements.

25 Now, you explain that you consider that the

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1 So I do think there are areas of learning both about
2 the understanding of the risk about the task that is
3 being undertaken, whether you can practise some of the
4 control measures, and if you can't, how PPE is used to
5 protect both you as the worker and the person you're
6 undertaking those tasks for, and those other control
7 measures, as I say, including PPE and otherwise. This
8 would mean, as we got to, that there would be an
9 increase in the demand for PPE itself. So it goes back
10 into, with this type of pandemic, you need to have
11 certainty about your supply lines and ideally a larger
12 stock than we had at the start of this pandemic, as
13 well.

14 **Q.** Can I just pick up on something you said, please, which
15 was the importance of ventilation. Do you think, during
16 this pandemic, Welsh ministers had enough access to
17 information about the ability of care homes to
18 ventilate, or is that also an area of learning?

19 **A.** I think it's an area of learning because our
20 understanding of ventilation developed through the
21 pandemic. If you consider the conversations we were
22 having in April compared to June 2020, compared to
23 December 2020, there's quite a lot of moving on.
24 I don't know if you recall that on one of the May bank
25 holidays, I think the late May bank holiday, a number of

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1 availability of PPE to the sector had improved
2 considerably. Now, whilst it may have improved, that
3 did mean that one-third of the sector's PPE needs were
4 not being met. And so my question is, can you provide
5 an overview of your understanding as to why that was the
6 position and how that position could be avoided in the
7 future?

8 **A.** I don't agree with the premise of the question. My
9 statement that two-thirds of the PPE needs were being
10 met by Shared Services shows the amount that was being
11 delivered by Shared Services. The other third, we
12 didn't receive complaints there was no PPE available and
13 people were managing without it, it was actually about
14 how they were securing, potentially through alternative
15 means, their own PPE supplies.

16 So we're taking up the slack -- well, the challenge
17 are the two-thirds of the sector at this point in time
18 and it's being done through Shared Services with no cost
19 to those care homes that require it, but other care
20 homes are still managing to get some PPE for themselves.
21 So that's the point I'm trying to make, rather than
22 a third of care homes are left without PPE. I wouldn't
23 want to leave that impression out there because that's
24 not what I'm trying to get over in my evidence.

25 **Q.** I'm grateful for the distinction, Mr Gething. The

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1 Inquiry has heard evidence, however, that throughout
 2 April there were difficulties, and what I'm seeking to
 3 address is, getting this programme off the ground, is
 4 there any learning for the future about the original
 5 delays? I appreciate what you're saying in respect of
 6 May, but throughout April, is there any learning about
 7 why there were shortages as it was being established?

8 **A.** Well, I think that is really about how quickly you're
 9 able to significantly increase supply, and not just the
 10 global supply that comes into a country, but actually
 11 how you then distribute that as well. So we made use of
 12 the joint equipment stores that local authorities had,
 13 because people were used, in a local authority area, to
 14 accessing information and supplies to and from that and
 15 distribution from local authorities.

16 How quickly people actually bought into wanting and
 17 needing to have supplies provided by NHS Shared
 18 Services, it's not just Carmarthenshire that said it
 19 would go alone and then had to come back because it
 20 couldn't source those supplies. So I think the learning
 21 is how quickly are you able to make a choice that you
 22 need to be able to source supply in a different way and
 23 the myriad procurement arrangements are not going to
 24 hold up to the pressure that they'll be under.

25 It's then also about where and how do you get that

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1 essential" and do you think that guidance could have
 2 explained more clearly the intention behind what that
 3 meant?

4 **A.** So we were thinking about compassionate visits, and that
 5 would include end-of-life care. And I think later
 6 guidance clarified that. So if, in the first iteration,
 7 we'd been able to describe what we subsequently did,
 8 that could have helped. So it's -- I think it's
 9 reasonable to accept that that description, if it was
 10 provided early, would have helped everyone.

11 **Q.** Would you agree, similarly, in respect of end of life,
 12 because the Inquiry has heard evidence that that was
 13 interpreted in some cases to mean the last few hours or
 14 the last few days, whereas some providers interpreted
 15 that more widely. Do you think it would have been
 16 helpful to give a definition or more guidance on
 17 interpreting end of life?

18 **A.** I can see that. I think there's a note of caution here
 19 in that the level of detail you go into in the guidance
 20 can give you certainty up to a point, but you need
 21 people to understand and implement the guidance. The
 22 longer and more complex the guidance, the harder it is
 23 to successfully and consistently implement. So there is
 24 a balance to be struck here. But I think as we go
 25 through the pandemic, we're learning more about what

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1 outside of the UK, and how quickly can you scale up home
 2 production of that? Because, you know, lots of PPE that
 3 is produced in the UK is more expensive than sourcing it
 4 internationally. And so the tyranny of numbers and
 5 budgets means that you are going to supply that in
 6 normal times by procuring it from overseas. If those
 7 supply lines are breaking, how quickly can you get up
 8 supply here in the UK and for private businesses to
 9 repurpose what they're doing?

10 So I think there is learning in that, but it still
 11 relies on your understanding of the pandemic you're
 12 facing, the stock you have available to you, and how
 13 quickly you're able to interact with an international
 14 market with a purchaser, a procurer, that has a success
 15 track record, and then your points earlier about the
 16 amount of stock and how that gives confidence within the
 17 system with the wider public, I think are relevant too.

18 **Q.** I'm going to change topic again, please, and can I move
 19 on to visiting.

20 Now, you explain in your statement at paragraph 207
 21 that the first piece of guidance for the care sector on
 22 visiting was communicated on 23 March 2020 which advised
 23 that visits to care homes should only take place when
 24 absolutely essential and not part of routine visiting.
 25 What was the intention behind the phrasing "absolutely

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1 helps to meet the needs of providers and the public who
 2 are interacting with the sector. But I think it is
 3 important to put on record that it's important to strike
 4 a balance on that because otherwise, if you write
 5 a telephone directory of guidance covering everything,
 6 that's not a fair fight for a care home provider to go
 7 through that, understand it, and implement it with the
 8 speed that was required.

9 **Q.** To what extent was the impact on disabled people and
 10 those with dementia, who often relied upon their family
 11 members to advocate on their behalf in respect of care,
 12 considered particularly in respect of those blanket
 13 bans, for example from 23 March?

14 **A.** It was really difficult, because again, you have this
 15 balance of -- for people and their general sense of
 16 wellbeing, the visits are a part of what helps to
 17 maintain that. When you interrupt that, that will
 18 impact residents. The alternative challenge is, though,
 19 that if you have regular visiting continuing, then
 20 you'll see more Covid in more care homes, with all of
 21 the consequences that come with that.

22 So, you know, this isn't straightforward, and you're
 23 trying to balance and manage all those risks and rights,
 24 and at the same time, at this point, the real and
 25 reasonable fear is that if you don't put more protection

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1 to restrict the number of people that go into care
2 homes, then you will see harm go into those care homes
3 that you can't undo.

4 **Q.** If the Welsh Government was to approach this situation
5 again now, in the future, are any lessons learned from
6 the experience of visiting, and would you do anything
7 different next time?

8 **A.** Yes, so I think with the benefit of hindsight and the
9 learning we've got, the point I made earlier around
10 ventilation is important and relevant because you could
11 undertake more visiting at an earlier point,
12 successfully, or with an acceptable level of low risk.
13 Because I think it's important to recognise that
14 visiting is an activity that comes with risk, but
15 there's a balance with that risk about what happens to
16 the resident without visiting, as well.

17 When you have the ability to visit outdoors, that of
18 course is safer, as we now know. So I think there are
19 things that you could do, to think about the position we
20 reached on visiting where outdoor visits, particularly
21 in times of lower prevalence, were managed successfully,
22 even in times of higher prevalence, visiting with social
23 distancing was possible outdoors and in the pods that we
24 helped to procure as well. Where people couldn't move
25 outdoors, the control measures you could be undertaking,

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1 visiting guidance.

2 Now, on 5 June, a letter was written to the sector
3 following the move to Stay Local on 1 June, so that was
4 five days later, and you say this prompted a lot of
5 queries regarding the position on care home visits.

6 Looking back, do you think it would have been
7 helpful to consider and produce guidance ahead of those
8 types of larger moves for the rest of the community?

9 **A.** Yeah, I think the capacity of the government to do
10 everything all at the same time, and to work with
11 different stakeholders, and -- you know, as we go
12 through, when you think about where we were in May and
13 the amount of headroom we thought we had to make
14 changes, to get all that ready, to get the guidance
15 ready, you've got to anticipate that and look at that
16 earlier.

17 If there was future pandemic I think we would be
18 anticipating this and there would be an opportunity to
19 do this sooner. But I think at the time -- at the time,
20 I don't think it would have been reasonable for me to
21 say that we would have been able to do this much, much
22 earlier. In the future, though, it would be a different
23 consideration because of what we learnt in this
24 pandemic, and the ability to apply that in the future.

25 **Q.** Regarding responsibility for visiting decisions or the

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1 including ventilation, to allow visiting to take place.

2 It's much like when we think about visiting as an
3 accompaniment for healthcare services, think about
4 people who were pregnant and weren't able to have their
5 birth partner with them, we've recognised before in
6 different modules that we want to revisit that and in
7 the future do that differently.

8 In care home visiting I think it's important to
9 recognise that the knowledge we now have, we'd have
10 a different approach to it. The counterfactual of
11 course is a confidence in what you're doing. Some
12 people were so desperately concerned, and rationally so,
13 that the idea that large numbers of visitors were still
14 coming into care homes would be something they would be
15 unhappy about, but if you are able to point out, we
16 think, this pandemic, there are control measures we can
17 undertake, ventilation is one of them, adequate supply
18 of PPE is another, and we now have rapid lateral flow
19 type tests that mean that we can help reduce the risk
20 further, then you could have a very different approach
21 to visiting much earlier and that would definitely
22 benefit residents who, I accept, had their wellbeing
23 compromised by the control measures that were introduced
24 at various points in the pandemic.

25 **Q.** Can I briefly ask, please, about timeliness of guidance,

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1 guidance that's produced, Ms Herklots told the Inquiry
2 yesterday:

3 "I think ultimately it needs to be a clear decision
4 by Welsh Government, because it is the body that can
5 coordinate what is happening.

6 "It felt to me that they were waiting on advice from
7 Public Health Wales, and therefore it felt like, maybe
8 almost by default, it was a sort of Public Health Wales
9 decision. So I think in -- in any pandemic in the
10 future, I think, you know, governments need to own those
11 decisions, and they need to be clear about where they're
12 taking advice and then the decisions that they're making
13 as a government on that basis."

14 Do you have any comments on what she said, please?

15 **A.** Well, the government does own the decisions we made.
16 And, you know, you have to take advice and guidance from
17 people with expertise, and Public Health Wales are there
18 for that purpose. The challenge then is how you
19 communicate that, and how quickly and rapidly and
20 consistently you can communicate that as well.

21 So if the suggestion is that we essentially devolved
22 our responsibility, I don't accept that. We took
23 decisions and we had to explain those decisions, as we
24 did on a regular basis.

25 In the future, as I've said in answer to your

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previous question, I think we'd be able to make some of those choices earlier, to draw in stakeholders, both Public Health Wales but also stakeholders within the sector as well, to understand, with a pandemic that's in front of you at that point in time, how quickly can you move.

And then, of course, we move to a position where local authority level decisions were able to be made on changing visiting as well. Because a situation in Gwynedd could be radically different from a situation in Bridgend, and so trying to make a national choice about all of those would actually get in the way of making the right choice. But the incident management team process is important to make sure you've got local public health advice from Public Health Wales and your health board, together with the local authority and the homes, to understand what choice you're making, so it commands support from all of the stakeholders who need to be there to make it work. And I know that we had a couple of instances where that didn't happen.

Q. Thank you, Mr Gething. I have just two final questions for you, please.

Firstly, the Welsh Government produced a Care Homes Action Plan, which focused on six areas: infection prevention and control, personal protective equipment,

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and all of their energy is invested in doing that, to then say we want to have a new action plan delivered on top of that, you've got to make certain there's capacity to do it and the ability to learn, to then see if you need to do something differently as well.

And I think the earlier demands, you know, on the Older People's Commissioner were at a time where actually it wasn't the right thing to do, but we did do it over the summer and, like I said, those relatively low prevalence levels gave us the space to do that, to try to be in a better position for the autumn, but that learning, that is now there, and I hope that both with this Inquiry and what we're doing anyway, that learning won't be forgotten and will inform future action.

Q. My final question, please: other than anything we've already covered in your evidence, are there any particular recommendations you think are important for these Inquiry to consider? Specific to this module, please.

A. Right at the end of my statement I've set out a range of -- I think I've invested in three, and I think one we haven't covered is the consistency of isolation facilities in residential and nursing homes.

There's a point there about future reform in the sector, but this would be something that I think would

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general and clinical support for care homes, residents' wellbeing, and social care sectors' wellbeing, and financial sustainability.

And the Inquiry understands that there were regular updates provided to the deputy minister on progress. Do you think that would be a useful tool for the future and did you find that beneficial?

A. I think so. The Care Homes Action Plan was drawn together with learning from the first phase in the pandemic about what had worked and what hadn't worked. And the fact that we had someone with expertise and understanding in the sector to do that fairly quickly was also, I think, fairly helpful, and I think it did help with the level of buy-in.

If you're looking at a future pandemic with the level of learning we have now, it would be possible to take an earlier look at what is happening practically within the care homes, to understand how the pandemic planning that we as a nation would have at that point is being implemented, how successfully or not, and how to understand and deliver learning.

The warning note I think to sound is, and I think it's a reasonable one, is that if you're going to do that you need to have the space and the time to do it. If people are dealing with the emergency in that moment,

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be relevant to every flu season, and every outbreak of an infectious condition in normal times, and would also provide, I hope, a greater success rate about the ability to isolate residents in a supported environment in the future as well.

That would require both a review of the sector and also some investment on a consistent basis, on how those facilities are maintained, as well.

MS PAISLEY: I'm grateful, Mr Gething.

My Lady, I've no further questions but there are some Core Participant questions.

LADY HALLETT: Thank you very much, Ms Paisley.

Mr Gething, as you know, there will now be some questions from the Core Participants. I only allot them a certain amount of time so I'm sure they'll be grateful and I'd be grateful if you keep your answers as short as you reasonably can.

Mr Stanton.

Questions from MR STANTON

MR STANTON: Thank you, my Lady.

Good afternoon, Mr Gething.

A. Good afternoon, prynhawn da.

Q. As you know, I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. I have a small number of topics to cover with you and the first relates

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1 to the decision that you took on 25 November 2020 to
2 delay the use of the Pfizer vaccine in care homes for
3 the first four weeks of delivery.

4 You address this issue at paragraphs 302 to 321 of
5 your statement, and at paragraph 304 you acknowledge
6 that the advice of the Joint Committee on Vaccination
7 and Immunisation, on 25 September 2020, was that the
8 first priority group for vaccination should be older
9 adult residents of care homes.

10 The reason elderly care home residents were the
11 first priority group was because of their extreme
12 vulnerability, and in this respect, scientific studies
13 record the case fatality rate of elderly, unvaccinated
14 care home residents as high as 36%. That is,
15 approximately one in three infections proved fatal.

16 And for the Inquiry record, this data is taken from
17 the research paper authored by Professor Shallcross and
18 others at INQ000544928, which identified that of
19 607 residents with confirmed infections, 217 died.

20 Mr Gething, given these alarming statistics, do you
21 accept that by not following JCVI advice to prioritise
22 care home residents for vaccination, you failed to
23 protect them?

24 A. No, I don't accept the formulation of the question.

25 If you look at all of the evidence I have provided
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1 you'll see it reads:

2 "... on 25 August 2020, it was recorded that there
3 was a significant risk of insufficient freezer storage
4 being available to store a vaccine requiring
5 a temperature of -70 degrees centigrade, should such
6 a vaccine receive regulatory approval. The mitigating
7 action was 'assess current and identify additional
8 sources of appropriate freezer capacity' ..."

9 And if we could separately look at some data
10 provided to Care Inspectorate Wales around the
11 notification of deaths in care homes around this time.

12 At INQ000198645 at tab 9.

13 Again, hopefully you have that before you.

14 Mr Gething, if I could draw your attention to
15 columns D and E and rows 10 through to 16, you'll see
16 there suspected and confirmed Covid deaths are recorded,
17 and we can quite clearly see the tail end of wave 1, and
18 then through July, August, September, numbers remaining
19 relatively low, before starting, sadly, to build again
20 in October, through November and December, and then
21 reaching a peak in January.

22 I'd suggest to you, Mr Gething, that the summer and
23 early autumn of 2020 provided an opportunity to take
24 action in respect of the need for refrigeration and
25 other measures in order to be able to deliver the Pfizer

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1 and -- in my statement, not just paragraphs 304 but
2 paragraphs 305 and 306 as well, I'm setting out the
3 challenges of delivery of the Pfizer vaccine. It was
4 very different to the AstraZeneca one, which was much
5 more portable. We needed ultra-low freezer storage and
6 actually the ability to successfully deliver that. So
7 this was a point that I discussed with officials
8 delivering the programme. I know Dr Richardson gave
9 evidence on this in the vaccines module as well, and on
10 paragraph 306 there's the pilot for the rollout, where
11 we looked at a care home in Betsi Cadwaladr, and the
12 learning from that to understand how that would then be
13 introduced as quickly as possible, because I always
14 understood that vaccination, in the absence of
15 a curative treatment, was going to be essential for us
16 to get out of the pandemic.

17 Q. Thank you.

18 Mr Gething, could we have a look, please, at the
19 statement of Dr Richardson. You just mentioned her
20 evidence in your answer just now.

21 Can we have up on screen, please, INQ000501330_0018.

22 Hopefully you have that.

23 A. I have that in front of me, yes.

24 Q. Thank you.

25 Mr Gething, at the second sentence of paragraph 67
90

1 vaccine. Would you accept, Mr Gething, that more action
2 ought to have been taken in this period to ensure you
3 were in a position to vaccinate the most vulnerable?

4 A. I think when you look at all of Dr Richardson's
5 evidence, it does go through the fact that the
6 Vaccination Programme Board were looking at how to try
7 to manage the Pfizer vaccine. It wasn't certain this
8 would be the first candidate vaccine. That was never
9 a discussion I had until much later. There were real
10 challenges, though, that the Vaccine Programme Board had
11 with not just the ultra-low freezer element of it but
12 actually the ability to move it around and get it from
13 one care home to another. So there were real practical
14 challenges in how to do that.

15 And when we look at the figures that you've
16 highlighted, this is -- the fact that this is the
17 reality of the fact that more Covid in circulation and,
18 by this point, in November, December, January, with the
19 more transmissible variant as well, that's when these
20 figures are showing.

21 Now, of course, if we'd been able to introduce any
22 successful vaccine earlier, we could have seen an impact
23 in these mortality figures, but we needed to be able to
24 deliver that vaccine safely to all of the people who
25 needed it. And that's what we tried to do.

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1 Q. Thank you, Mr Gething.
 2 Vaccinations in Wales commenced on 8 December 2020.
 3 However, by the end of January, nearly two months later,
 4 you'd only vaccinated 11,000 care home residents or
 5 around 67% of the population. This is confirmed in the
 6 vaccines weekly update of 26 January 2021, which is at
 7 INQ000508504. However, I don't think we'll need to go
 8 to this document because you deal with this issue,
 9 Mr Gething, in paragraph 310 of your statement.
 10 At page 2 of this update, it's also confirmed that
 11 some 290,000 people had been vaccinated in Wales by this
 12 time, which means that care home residents had been
 13 leapfrogged by several other priority groups. And in
 14 this regard, Mr Gething, please can I refer you to
 15 evidence which I'll ask is brought up on screen of
 16 Professor Lim that was given to the Inquiry during the
 17 Module 4 hearings.
 18 This is at PHT000000143_0023.
 19 And when you have that, Mr Gething, the section I'd
 20 like to refer you to is at page 89 of the transcript
 21 from line 17, and it reads:
 22 "... the number needed to vaccinate to prevent one
 23 person from dying in cohort 1 was calculated by the
 24 institute of actuaries as 20. In other words, if we
 25 vaccinated 20 people who are residents in an old age
 93

1 large numbers of people, really quite quickly, and the
 2 scale and the pace of the vaccination programme
 3 significantly increased through January and February, as
 4 the lessons learnt from practical delivery were applied
 5 in practice.
 6 Q. Thank you, Mr Gething.
 7 Just in respect of an answer you gave there that you
 8 were following JCVI advice, Wales was the only country
 9 to delay provision of the vaccine and indeed, other UK
 10 countries had noted that, Westminster Government noting,
 11 in a meeting on 12 January, that the Welsh Government
 12 was different to other nations and they had prioritised
 13 NHS staff. So I'm not sure I accept what you say in
 14 respect of following JCVI advice.
 15 A. We didn't delay the delivery of the vaccine, and
 16 I certainly wouldn't take as gospel a statement by the
 17 UK Government. You'll recall this was a highly
 18 contested political environment at the time.
 19 I undertook a huge amount of work practically with the
 20 Vaccine Delivery Group. This is a part of the pandemic
 21 I recall really vividly. The amount of time and
 22 different days, using my son's bedroom to run meetings
 23 to understand where we were, to understand the pace we
 24 could inject, and at the same time, there was quite
 25 difficult and sharply political criticising within Wales
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1 care home, we would protect one life.
 2 "The same number needed ... to protect one person
 3 from dying in a 65-year old cohort was 1,000, and the
 4 number needed to vaccinate ... to save one life in the
 5 50-plus cohort is 8,000."
 6 Mr Gething, having regard to this information, do
 7 you accept that had care home residents been vaccinated
 8 promptly in accordance with JCVI advice, many more lives
 9 could have been saved?
 10 A. Our vaccination programme acted in accordance with JCVI
 11 advice. If there's a suggestion that we ignored that,
 12 that is one that I do not agree with, and I don't think
 13 the evidence bears that out. You put to me
 14 paragraph 310 of my statement, and in paragraph 310 of
 15 my statement I explain why we hadn't been able to
 16 vaccinate 70% of people over 80 and in care homes.
 17 There'd been a range of factors in that that were beyond
 18 our control, but if you can't vaccinate residents in
 19 care homes it doesn't mean you should not vaccinate
 20 other people in those top two risk groups, because the
 21 JCVI advice was to vaccinate people in the top two risk
 22 groups. And that's how the cohorts were working and
 23 that's what we did.
 24 So, and when you look at what we did in our
 25 vaccination programme, we were successful in getting to
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1 and outside, and I do reject the suggestion which I find
 2 offensive that we were sitting on the vaccine, and
 3 failing to meet our obligations and work in accordance
 4 with JCVI advice.
 5 And if you look at what we did in the vaccination
 6 programme in Wales, we had an efficient and fast rollout
 7 of the vaccine, and we covered our most vulnerable
 8 groups at real pace that led to us being able to make
 9 choices to leave the extraordinary lockdown they
 10 experienced in winter 2020 to '21.
 11 Q. Thank you, Mr Gething.
 12 I'll take you to another decision around this time,
 13 please, that I suggest similarly failed to protect and
 14 prioritise care home residents, namely the decision on
 15 15 December to allow what has been described as
 16 low-positive testing patients to be discharged from
 17 hospital to care homes.
 18 Your statement announcing this decision is at
 19 INQ000227285, which we don't need to bring up.
 20 The timing of this decision is at a point when you
 21 had suspended Pfizer vaccines in care homes and at
 22 a time, as we've just seen, when deaths were rising
 23 within care homes. Can I ask you, what impact did this
 24 change in policy have on infections and deaths in care
 25 homes in Wales?
 96

1 **A.** The change was made based on the advice that
 2 low-positivity readings were -- the low-positivity
 3 readings that we had changed advice on were ones where
 4 people were no longer infectious. It's covered in my
 5 statement, it's covered in the statement I issued at the
 6 time, and it's also referred into Professor Khaw's
 7 evidence that he's given to this Inquiry as well. The
 8 suggestion that that had somehow lead to an increase in
 9 infections in care homes is not one that is borne out by
 10 the evidence.

11 **Q.** Can I then, please, Mr Gething, please take you, and
 12 have up on screen, to the advice of the Technical
 13 Advisory Group of 11 December 2020 upon which your
 14 decision was based.

15 That's at INQ000350671_0002. And at the top of that
 16 page, when you have it, you'll see the statement:

17 "There remains uncertainty around the period of
 18 infectivity for individuals infected with SARS-CoV-2."

19 This document does go on to indicate that there was
 20 high confidence in the decision around low-level
 21 positive testing. However, nevertheless, there remained
 22 a risk. My question to you is, given the extreme
 23 vulnerability of care home residents, the way that the
 24 virus, once it was seeded within care homes, rapidly
 25 spread within it, the fact that care homes were ill

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1 **Q.** Thank you, Mr Gething.

2 My final question relates to paragraph 96 of your
 3 witness statement which I'd be grateful if we could have
 4 up on screen, please. That's at INQ000587254_0023.

5 And you'll see there, Mr Gething, the first line of
 6 that paragraph:

7 "As ever, the most vulnerable people in Wales were
 8 at the heart of the decision-making process ..."

9 Mr Gething, having regard to the risks taken with
 10 the safety of elderly people in care homes just
 11 described, can you legitimately make this claim?

12 **A.** Yes. If you look at the choices we made, we made
 13 whole-society choices to protect the most vulnerable
 14 people and we knew that Covid as a condition, was
 15 something that affected people with particular
 16 additional healthcare conditions, and age was
 17 a significant factor. And that's why the JCVI advice on
 18 vaccination placed a high regard on the age of
 19 individuals.

20 So in an NHS hospital, on any day, the people in
 21 a hospital bed are overwhelmingly older people. Those
 22 people are vulnerable when hospital is no longer the
 23 right place for them. Those people living in their own
 24 homes, outside of a hospital, are more vulnerable if
 25 they get Covid. If those people need to move from their

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1 equipped to cope with infection breakouts, and at a time
 2 when vaccinations had been suspended in care homes, why
 3 were you willing to take this risk, even a small risk?

4 **A.** Just coming back to where and how you judge risk and
 5 harm, if you have someone who is low positive, and keep
 6 them in a hospital setting, then that person is at risk
 7 of greater harm. And the evidence that we point to here
 8 does not justify keeping that person in that state.

9 There is risk from care home staff going into a care
 10 home every day, but you understand those people have to
 11 go into the care home to undertake their work. And this
 12 is a decision that is based on the evidence at the time,
 13 and I have not seen any evidence that this decision led
 14 to infections in care homes.

15 And, you know, this is the point about learning what
 16 to do in a future pandemic. And if you want to take
 17 zero risk choices, then those choices will in themselves
 18 cause harm. And this is both the harm for the person
 19 who is in the wrong place, but also the harm to the
 20 person who can't get into a hospital when it should be
 21 the right place for their care and treatment to take
 22 place, and I have responsibility for the whole country,
 23 not one section of it. So this is an evidence-based
 24 choice, and I think it's important decision makers in
 25 the future make choices based on the evidence.

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1 home, into a hospital, you need to have a hospital bed
 2 for them. You need to do this in a way that recognises
 3 the risks in the community, in an ambulance, in
 4 a hospital, in a care home, and those people are then
 5 returning to their own home as well, and all of the
 6 staff who are engaged in that as well, and that is why
 7 we made whole-society choices on what to do to manage
 8 those risks, to understand the balance of harm in every
 9 choice that you have to make.

10 And that is the way that I approach making choices,
 11 and those are still the concerns I have in approaching
 12 this Inquiry about how you understand how not just the
 13 choices we made, but the choices you could make in the
 14 future, with a similar or even a different pandemic, and
 15 the choices that inevitably any decision maker will have
 16 to face.

17 **MR STANTON:** Thank you, Mr Gething.

18 Thank you, my Lady.

19 **LADY HALLETT:** Thank you very much, Mr Stanton.

20 Ms Morris.

21 **Questions from MS MORRIS KC**

22 **MS MORRIS:** Thank you, my Lady.

23 Mr Gething, can you see and hear me okay?

24 **A.** I can indeed.

25 **Q.** Thank you, good afternoon. My question is about

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1 visiting restrictions, please, and the Inquiry has heard
 2 evidence, and has evidence before it, from Heléna
 3 Herklots, the Older People's Commissioner for Wales that
 4 in her view the initial guidance did not take account of
 5 the harm to health and wellbeing from older people of
 6 being isolated and, in fact, you said in your statement
 7 that as of August 2020 you were aware of the growing
 8 concern expressed by the Older People's Commissioner and
 9 others about the negative impact that the restrictions
 10 on visiting and physical separation from loved ones was
 11 continuing to have.

12 Is it fair to say that there was a lack of
 13 understanding about care homes and the rights of older
 14 people in visiting guidance, particularly in the initial
 15 stages?

16 **A.** No, I don't think so because in the initial stages, you
 17 will recall, in March, we were just going into lockdown,
 18 and we have a transmissible condition that is more
 19 likely to affect older people in particular, and we
 20 don't understand everything about how it is transmitted
 21 but we do know that there are real risks, and we're
 22 facing up to a reasonable worst-case scenario where over
 23 half a million people could die.

24 So the choices made at that point were rational.
 25 You then understand the more direct impact of those

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1 what that was.

2 So I don't seek to change the evidence I've given in
 3 that regard, but I don't think it's fair to say that in
 4 March 2020, just after going into lockdown, we could
 5 have enabled safe visiting at that point in time,
 6 because we just didn't have the knowledge base to do so.
 7 A future pandemic, we have different considerations to
 8 take into account about how to have a lower level of
 9 risk to enable more visiting to take place, whether
 10 outdoors or potentially indoors, as I've described in
 11 earlier evidence.

12 **MS MORRIS:** Thank you very much.

13 Thank you, my Lady.

14 **LADY HALLETT:** Thank you, Ms Morris.

15 Ms Peacock.

16 **Questions from MS PEACOCK**

17 **MS PEACOCK:** Thank you, my Lady.

18 Good afternoon, Mr Gething. I ask questions on
 19 behalf of the Trades Union Congress. My questions
 20 relate to the concerns raised about PPE provision in the
 21 social care sector, and if we could bring up your
 22 witness statement on screen. It's at paragraph 175.

23 Hopefully you have that in front of you?

24 **A.** I do.

25 **Q.** You describe:

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1 choices as you get deeper into the pandemic, and of
 2 course the Older People's Commissioner was also saying
 3 at various points in time that she wanted more
 4 protection around care homes. Well, visiting is part of
 5 the risk. It's also part of how you maintain a general
 6 sense of wellbeing in the health of people in those care
 7 homes. It's about striking the balance that's
 8 important. And I said in my statement that we would
 9 need to consider how that balance is struck, and in
 10 earlier evidence about how that balance could have been
 11 struck at an earlier point to enable visiting with
 12 a much lower level of risk than we understood in
 13 March 2020.

14 **Q.** So in hindsight, ought the focus to have been on
 15 enabling safe visiting, rather than a blanket ban?

16 **A.** Well, in hindsight I think we could have moved faster on
 17 enabling safer visiting, low-risk visiting. That's the
 18 point I made in answer to the Inquiry. But in
 19 March 2020, when we go into lockdown, and when the
 20 restrictions come in place, we're not aware that we can
 21 enable safe, low-risk visiting generally, but there is
 22 still a provision for compassionate visiting. We've
 23 gone through the issues around exceptional circumstance
 24 visiting and how the guidance could have been written in
 25 a way that enabled people to understand more clearly

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1 "Concerns about PPE were also raised by Trade Unions
 2 representing the care sector. On 30 March ...
 3 I received a letter from the GMB union ..."

4 And then you go on to say several lines below:

5 "My initial response to the letter was that some of
 6 the demands set out were unachievable; on PPE,
 7 I commented that 'It is an odd position to be put in
 8 when the GMB are demanding that we equip the private
 9 sector staff with PPE that I assume the employer is
 10 legally responsible for from the public purse.' In
 11 effect, the letter was seeking priority over publicly
 12 funded provision we were more directly responsible for
 13 us to [provide] the sector over."

14 If we could bring that letter up on screen, it's at
 15 INQ000180891, at page 1.

16 Hopefully you now have that on screen.

17 The letter states on the first line of the first
 18 page:

19 "GMB Union represents members right across Social
 20 Care, both public and private employees.

21 "We understand that these are exceptional times and
 22 advice and guidance is changing daily."

23 Then if we could turn over to the second page, the
 24 second paragraph, regarding PPE and social care, states:

25 "Our members in the independent private sector feel

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let down at a time when they have put themselves on the frontline. GMB has been contacted by Managers in despair at feeling they are putting their staff in harm's way and are unable to do anything to protect them, as I seems the PPE that you have requested be released isn't getting through to ... those that need it ..."

Then in the final sentence of that paragraph, it states:

"The health and safety of key workers must remain a priority ...

"1. Can you please advise me of what you are doing to address this crisis within a crisis?"

I just want to clarify the request made in that letter from GMB. Can you agree that there is no request in that letter for one set of workers to be given priority for PPE over another set of workers? In fact, the letter simply raises a serious issue around access to PPE in the private sector for care workers, and asks for an explanation from Welsh Government of their approach to the issue?

A. No, well, I think the letter points out that their particular concern is about members in the independent private sector, and of course it calls on workers remaining a priority whilst -- government and all

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priority given is to one particular set of workers. In fact, the GMB explicitly mentions that they represent both public and private employees, and the request is that the health and safety of all key workers must remain a priority rather than suggesting that one are given a priority over the other; is that right?

A. It then goes on to give examples only from the independent sector as well. We're not legally responsible to the independent sector, for the provision of PPE. This is about how the resources of the government are used. And if we need PPE that is available for people who we're directly responsible for, then we've got a responsibility to do that. That's the point I'm trying to make in my email correspondence. I should point out I'm a member of the GMB. I know it's in my statement, but --

Q. I am grateful. I just wanted to be very clear about what the request from the GMB was in that letter. And you acknowledge in your statement at that same paragraph we've touched upon that supply chains for PPE collapsed. Do you agree that in those circumstances, in a pandemic where private employers are seeking to, but are unable to provide their employers with PPE, it's reasonable to ask the government to step in and address supply?

A. Which is what we did.

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employers.

Now, this goes back to who we are and aren't legally responsible for, but also the fact that the government is the last resort. Well, if the government can't resolve it, you call in the military. Which we did, of course, during the pandemic. So it's about a demand that PPE is released to the independent sector, but that then means are we -- my concern is do we have enough to deal with all those people we are responsible for?

It's about trying to understand what we can do and how quickly we can do it, and the challenge of maintaining confidence and making sure that people do get supplies of PPE that they need. And as I've said in previous evidence, I think we did this rapidly through Shared Services, and fairly successfully, but that doesn't mean that there weren't uncomfortable circumstances for staff at the time, which I recognised both in my evidence to this Inquiry and indeed at the time -- I think I said that PPE was a bigger concern for me at various points in time than testing because of my concern that we wouldn't have adequate PPE for frontline workers to use.

Q. Thank you for your explanation about the concerns which you had arising from the letter, but I just want to be very clear that the request made by the GMB is not that

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MS PEACOCK: I'm grateful.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Peacock. It's now Ms Jones.

Questions from MS JONES

MS JONES: Thank you, my Lady.

Mr Gething, I ask questions on behalf of John's Campaign, The Patients Association and Care Rights UK. You said in your evidence this morning that the voice of unpaid carers was significant throughout the pandemic, but the experience of the organisations I represent was that there was little support provided for unpaid carers, including the millions of people who newly found themselves providing unpaid care to loved ones during the pandemic and who were simply expected to step up and fill the gaps created when healthcare, care and respite services were suspended.

My question is this: to what extent did you and the Welsh Government consider the impact on unpaid carers of decisions like expedited hospital discharges at the same time that other services were being suspended, and what, if anything, did you and the Welsh Government do to reduce the strain being put on unpaid carers?

A. This developed through the pandemic, and I think I've gone through this several times in evidence in writing

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and in different modules as well as today. The decision on the 13th is about how you manage the risk that the whole country is facing and the harm that the whole country is facing. And if you're not prepared to act, then you're essentially accepting that your health and social care system is going to break down, with potentially catastrophic harm to staff and to the public.

And in understanding what you can do to support unpaid carers, we had a range of things that we did, from food delivery to the work that we did with the Carers Trust, and that came on the back of not just having a regular voice in press conferences but actually engagement with carers organisations about how you try to provide practical support for them.

And you're right, there were people who had new responsibilities they hadn't had before, but those were driven by, I think, unavoidable choices to the way the health and social care system needed to change rapidly to avoid being overrun.

In a future pandemic, I think we'd be better prepared for what that means for different groups of people. I've said myself, I've had to take on new responsibilities, relatively low level, but I had to do those and my job because there wasn't alternative

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A. Yes, it -- if we'd had more reliable data, then it would have allowed us to have a better overview of the sector, potentially where and how we get information but also resources to parts of that sector as well. I don't think there's any dispute with that.

Q. Thank you.

And in terms of the kind of data that might be necessary, the organisations I represent are concerned that there are particular holes around lack of data about bed capacity, number and identity of staff, and the type of services that are provided at different care settings, but also that there's a lack of qualitative data reflecting the views of people who draw on care and, for example, the impact on them of things like the Covid-19 visitor restrictions.

From your experience during the pandemic, do you agree that these are areas where better data collection is necessary and do you have any views on how such data could be collected in order to inform decisions that were made?

A. So the understanding of bed numbers and settings, having a clearer handle on that would obviously be useful. You understand more about what you're able to do in terms of flow through the whole health and social care system. The recommendation that I've made, that Counsel to the

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provision in place, because the advice we were giving people meant they had to stay in their own home.

So, you know, that's a pretty significant undertaking for everyone, and it comes with a level of discomfort. And I do hope that when the Inquiry comes to reach its conclusions, there can be something about not just understanding what happened with unpaid carers but are there practical ways that we could provide support earlier?

And I think where we reached with the scheme we provided, through a carers organisation, in hindsight, and if you're looking at a future pandemic, we could have been able to do something about that earlier to provide more practical support for the role that unpaid carers were undertaking.

Q. Thank you, Mr Gething.

My next topic is about the problems with data about the care sector. You recognise at paragraph 79 of your witness statement for this module that data across the care sector was fragmented, and that is supported by evidence that the Inquiry has received from other witnesses in this module as well.

Do you agree that the response to the pandemic in adult social care sector was hampered by a lack of reliable data about the adult social care sector?

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Inquiry allowed me to highlight, around individual isolation for infection prevention and control, that's quite important as well.

When you're then talking about the qualitative experience, I think that should be a regular feature the way the health and social care system runs in terms of the access to whether it's patient care or the care that takes place in a social care setting and the value of it and, when that's withdrawn or is restricted, the impact that has, because that then allows you to understand more clearly the balance of harms that you've got to try to balance.

I still think it was inevitable there was going to be a restriction on visiting, because otherwise, you'd have imported much greater risk of harm into all those care settings. So it's about how do you enable some form of contact to be made? So we eventually, you'll recall this in my statement, that we provided a range of devices to homes that didn't have them to allow remote contact to take place, which isn't the same as in-person contact, and also the evidence I've given about whether you can take lessons from this pandemic to allow visiting to take place in a much lower-risk environment in the future, and I'm sure that (unclear words) the Inquiry will consider that when making its

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1 recommendations.

2 **Q.** Thank you, Mr Gething.

3 Can I just follow up on whether you have any views

4 on how that data could be collected or which bodies are

5 the organisations that you think should be collecting it

6 for future?

7 **A.** Well, it's different in Wales and England because our

8 systems are different, the same with Scotland. I think

9 the information inspectorate has its importance. But

10 it's also, I think, important for local authorities with

11 statutory responsibility to have access to predictable

12 and reliable data they can share with the Welsh

13 Government, as well, on those homes. Then the

14 qualitative data, I think when you're dealing with

15 a pandemic that has an infectious condition, it's really

16 hard to have that face-to-face contact to get that

17 qualitative data, as well. So you're going to be

18 reliant on how your normal systems, where it's

19 face-to-face it normally does, it can stand up to an

20 interruption of that.

21 So I think some remote conversations about that,

22 both with staff and with residents, would help in doing

23 that, and making sure that your snapshot is a reasonable

24 one.

25 I think there's a role for local authorities in all

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1 **LADY HALLETT:** Sorry, I overspoke. Good afternoon.

2 **MS CECIL:** May I please call Albert Heaney.

3 **MR ALBERT HEANEY (affirmed)**

4 **Questions from COUNSEL TO THE INQUIRY**

5 **LADY HALLETT:** Good afternoon, Mr Heaney, I hope we haven't

6 kept you waiting too long.

7 **THE WITNESS:** Not at all. Thank you very much, my Lady.

8 **MS CECIL:** Thank you, Mr Heaney. You're here today to give

9 evidence in relation to the role that you played during

10 the pandemic as -- and may I just confirm, you are now

11 the Chief Social Care Officer for Wales.

12 **A.** Yes, indeed.

13 **Q.** And I'm just going to go through a little bit of your

14 background. I'm not going to go through it in detail

15 because it's set out within your very helpful witness

16 statement but, in short, you began working as a social

17 worker within a local authority in Wales all the way

18 back in 1980?

19 **A.** 1988.

20 **Q.** 1988.

21 **A.** Yes.

22 **Q.** Thank you very much. Since then you've held various

23 wider roles, including the president of the Association

24 of Directors of Social Services Cymru, ADASS, Wales; is

25 that correct?

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1 of this, because the commissioner isn't going to be able

2 to provide that comprehensive view.

3 **MS JONES:** Thank you, Mr Gething. Those are all of my

4 questions.

5 **LADY HALLETT:** Thank you, Ms Jones.

6 Ms Beattie.

7 **MS BEATTIE:** My Lady, I do not have any questions, thank

8 you.

9 **LADY HALLETT:** Oh, right, sorry, have I misread it?

10 Well, thank you very much anyway.

11 Mr Gething, that completes the questions that we

12 have for you for this module. I'm afraid I cannot give

13 you any guarantees we won't be calling on you again.

14 I know we've called on you, is it five times already?

15 But like Mr Hancock, you played such a role during the

16 pandemic, I'm afraid there's no alternative. But I

17 promise you, we'll limit any burden on you that we can.

18 Thank you very much indeed for your help.

19 **THE WITNESS:** Thank you.

20 **LADY HALLETT:** Very well, we shall break now and I shall

21 return at 1.50.

22 **(12.48 pm)**

23 **(The Short Adjournment)**

24 **(1.50 pm)**

25 **MS CECIL:** Good afternoon, my Lady. May I please --

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1 **A.** Yes, indeed.

2 **Q.** Lead Director for Children, Lead Director for

3 Safeguarding and Prevention, you've chaired numerous

4 boards and committees with regard to safeguarding and

5 adult protection, and been the Corporate Director

6 of Social Services leading on children's and adults'

7 services?

8 **A.** Yes, that is true. Thank you.

9 **Q.** And immediately prior to the pandemic you were the

10 Director of Social Services and Integration within the

11 Welsh Government?

12 **A.** I was indeed.

13 **Q.** Turning to your role, then, in the pandemic and I'm

14 really focusing now on your role between March 2020

15 until June, initially June 2021, you were the Deputy

16 Director General to the Health and Social Services

17 Group; is that correct?

18 **A.** That's correct.

19 **Q.** And you were the deputy to Andrew Goodall; is that

20 right?

21 **A.** Yes, indeed.

22 **Q.** And then in June 2021 you became the Chief Social Care

23 Officer along with the Director of Social Services and

24 Integration. You held those roles concurrently?

25 **A.** Yes.

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1 Q. Thank you. In terms of how that sat within the Welsh
2 Government, I just want to break that down a little bit
3 because, on the face of it, it looks a little bit
4 complicated.
5 So in terms of the Welsh Government, we have the
6 Minister for Health and Social Services who holds
7 responsibility for adult social care?
8 A. Yes, indeed.
9 Q. That was Vaughan Gething until May 2021 and then
10 Eluned Morgan.
11 A. It was.
12 Q. And then in addition to that, there's also a deputy
13 minister that focuses on Social Services and that was
14 Julie Morgan throughout the relevant period?
15 A. Yes, indeed.
16 Q. Here, what we're concerned with is the Health and Social
17 Services Group that reported in to the minister; is that
18 right?
19 A. That's correct.
20 Q. At the time, as I've said, the Director General there
21 was Dr Andrew Goodall succeeded by Judith Paget?
22 A. Yes.
23 Q. And at that point, and this is relevant to why your role
24 changed, Dr Goodall was also chief executive of NHS
25 Wales; is that right?

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1 A. That was a new structure designed to respond to the
2 pandemic.
3 Q. Thank you. And that had various workstreams and we're
4 going to touch on some of them but testing, PPE,
5 vaccination, visiting, all of those types of areas.
6 A. Yes. So although it may not lead on all of those policy
7 areas within the group, they were clearly areas of
8 interest and importance to the directorate.
9 Q. Thank you. And when you say you may not lead on those,
10 so what we do have are other government departments and
11 groups leading on those different issues, you providing
12 support or collaboration on your specific areas of
13 expertise?
14 A. Indeed, and also ensuring that the social care
15 perspective is then understood and taken into account.
16 Q. Thank you very much.
17 Turning, then, in relation to the adult social care
18 sector, could you just provide us with a short summary
19 of how you saw the sector at the point of when the
20 pandemic began? So we're looking at between January to
21 March 2020. Just a very short overview.
22 A. Yeah, thank you. Thank you for the question.
23 My succinct overview would be that it was a very
24 fragile system, high turnover of staff, social care
25 staff, very low-paid workforce, and therefore went into

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1 A. Indeed so.
2 Q. So he held these two positions and as a consequence of
3 that, that's one of the reasons why you were made Deputy
4 Director, to take upon some of those burdens and
5 responsibilities?
6 A. Yes, Deputy Director General to support him in his
7 capacity.
8 Q. And the Social Services and Integration Directorate is
9 one directorate within the HSSG?
10 A. It is indeed.
11 Q. And that is responsible for policy within the adult
12 social care sector, but it's not responsible for
13 delivery and implementation.
14 A. No.
15 Q. And whose responsibility is that?
16 A. The responsibility for the delivery, then, for social
17 care in Wales rests with the 22 local authorities.
18 Q. Thank you. And in relation to the Social Services and
19 Integration Directorate, that had three divisions, but
20 in addition to those during the pandemic, there was
21 a Social Care Coordination Hub created; is that right?
22 A. Yes, indeed.
23 Q. Was that a new structure or was that one envisaged
24 pre-pandemic with regard to potential pandemic or
25 emergency situation use?

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1 the pandemic in a fragile, more vulnerable state.
2 Q. Thank you very much.
3 And just looking at capacity within the adult social
4 care sector, were there concerns with workforce
5 capacity? Were there sufficient members of staff,
6 effectively, to occupy that sector?
7 A. In terms of sector, it's a very fragmented sector. So
8 it has local authority provision, it has private
9 providers, independent sector, and it is fair to say
10 that staff -- workforce staff turnover, it's been
11 a constant -- is a constant challenge to the sector. So
12 it is a struggling sector going into it on terms of
13 workforce.
14 Q. Thank you. If I can just turn, then, to preparedness in
15 relation to the pandemic, you set out, in some detail
16 actually, the various exercises that the department and
17 the government, the Welsh Government, were generally
18 involved in, and those that pertained specifically with
19 aspects of adult social care. I'm not going to go
20 through those in great detail with you but what you do
21 explain is that aspects of that was paused owing to
22 Brexit preparations, and that's something that my Lady
23 has heard about previously.
24 But in relation to the pandemic planning at that
25 time, again, as we've heard on in other modules, that

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1 was predominantly focused on pandemic flu, and the
 2 primary pandemic preparedness group was the Wales
 3 Pandemic Flu Preparedness Group, and that last met prior
 4 to the pandemic in November 2018; is that right?
 5 **A.** That is true.
 6 **Q.** It reconvened then in January of 2020. And if I could
 7 just call up INQ000180621, please, we see here
 8 a 23 January paper that was prepared for that purpose.
 9 But can I just be clear about this, it does not appear
 10 that this is actually connected to Covid-19
 11 specifically; is that right?
 12 **A.** That is right.
 13 **Q.** There is no mention of Covid-19, so this is really
 14 talking about general contingency planning at this
 15 point?
 16 **A.** Yes, indeed.
 17 **Q.** It states:
 18 [As read] "Countermeasures and consumables to meet
 19 planning assumptions."
 20 A reference to the PPE stockpile. There's
 21 a reference to workstreams. We see healthcare demand,
 22 where they talk about surge demand for critical care,
 23 and in that regard hospital discharge was always
 24 envisaged; is that right?
 25 **A.** Yes.

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1 it would be fair to say a great deal of thought had gone
 2 into that across the sector, but in terms of the
 3 Covid-19, then I think my view would be that that
 4 preparation didn't enable us to be well placed when the
 5 pandemic took place.
 6 **Q.** In terms of practical consequences, did that mean that
 7 you were not quite starting from scratch but certainly
 8 had to begin, in terms of guidance and policies, from
 9 a very different starting point from what we'd hope to
 10 have been envisaged?
 11 **A.** Yes, indeed.
 12 **Q.** If I can just talk, therefore, now, to move to the
 13 pandemic itself, I don't know if you can help us with
 14 this at all, but on 25 February of 2020, Public Health
 15 England produced guidance for the care home sector. Are
 16 you aware as to whether or not the Welsh Government did
 17 the same?
 18 **A.** By that date I believe our guidance began to emerge in
 19 the March period.
 20 **Q.** Thank you. Now, if I may, I'd like to talk about or ask
 21 you questions, rather, about the hospital discharge
 22 policy in care homes. So at the outset of the pandemic,
 23 as we've discussed, it was always envisaged that that
 24 would be a potential route in terms of relieving
 25 pressures within the NHS in Wales. There was draft

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1 **Q.** We see adult social care demand. Again, surge?
 2 **A.** (Witness nodded)
 3 **Q.** Resilience. But whereas healthcare is specifically
 4 mentioned, if I can go to 003, please, where we see that
 5 healthcare is specifically mentioned, there is no
 6 mention of adult social care there at all, is there?
 7 **A.** No.
 8 **Q.** And the remainder deals with excess deaths,
 9 communications and legislation. As I say, I don't
 10 intend to go through any of that in detail.
 11 One consequence of all of the planning being based
 12 on pandemic flu was that you said that the guidance that
 13 had been produced was not designed for an emerging
 14 disease pandemic lasting more than two years. To your
 15 mind, does that represent a lack of preparation for the
 16 sector?
 17 **A.** In my mind, it represents a focus on a certain type of
 18 pandemic, but once we moved into Covid-19, then the
 19 requirements and demand were very different for that
 20 preparation. And indeed, I think that is potentially
 21 a real learning point for the future.
 22 **Q.** Indeed. To what extent, therefore, were then the
 23 existing plans for adult social care adequate?
 24 **A.** They were adequate in so much as, had it have been
 25 a pandemic flu that we were dealing with, then I think

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1 extreme surge guidance included as part of the paused
 2 pandemic planning?
 3 **A.** Yes.
 4 **Q.** That was later to be published in relation to Covid in
 5 April of 2020?
 6 **A.** Yeah.
 7 **Q.** But again, is it right that that did not provide any
 8 guidance to the adult social care sector on how to
 9 accommodate discharges, or any relevant IPC infection
 10 prevention and control measures?
 11 **A.** In relation to the surge guidance, I think there were
 12 some helpful issues and support in that guidance for
 13 social care. I believe that, from memory of the
 14 guidance and from the conditions at the time, that it
 15 was focused on some of the key issues that would have
 16 emerged around pandemic planning but with the early day
 17 learning around what Covid-19 was transmitting,
 18 et cetera.
 19 **Q.** There was no specific guidance contained within that in
 20 relation to the adult social care sector, was there, as
 21 in specific guidance as to what they would do in the
 22 event of a discharge?
 23 **A.** Not in terms of discharge. There was guidance, as
 24 I said, in there that I think was helpful to the social
 25 care sector. The hospital discharge guidance then

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comes, it is separate to that, yes, and you'll have the dates of that, of course, within my statement as well.

Q. Thank you. Now, turning then to 13 March, that was when Mr Gething announced the Framework of Actions. One of those actions, of course, was to expedite the discharge of vulnerable patients from acute and community hospitals. Now, in relation to that, ministerial advice was subsequently produced around a week later on 20 March. Why was there a need to produce that retrospectively?

A. Well, we would be, as a government, we would be preparing ministerial advice so there's a record of this decision. I think that in relation to the framework announced on 13 March that predominantly that was a system response from the NHS in Wales and therefore from a policy perspective that advice did follow, informal advice up to the minister, shortly after that announcement of the framework.

Q. Thank you. If I can just look at that with you for a moment. That's INQ000366593, and if we can go to page 3, please, this sets out the hospital discharge policy here, and what we can see is the need to expedite?

A. Yes.

Q. It says -- and in relation to that, the other actions

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a government, as a team, we were involved with other colleagues, medical and scientific.

Q. And really what I'm asking about here is that the advice that's been written in relation to hospital discharge focuses on the issue of discharge from hospitals and creating capacity. What it doesn't do is look at it through the other end of the lens with those individuals being taken into those care homes and what challenges and risks those care homes might face; is that a fair summary?

A. That's a fair summary.

Q. Thank you. Now, in relation to discharge of individuals with symptoms, you provided your advice and views, and I just want to draw up an email that you sent in relation to a query from a care home.

And that's INQ000336324, and it's going back to 23 March, and if I can go to page 3 first of all, please. Thank you.

As you can see here, it's a query that's coming up in relation to patients from what they consider to be a Covid-19 positive hospital, so we can take from there there's been at least an outbreak or they have diagnosed Covid-19 patients in -- within the hospital.

And there's a query coming up because:

"They are not showing symptoms but the home feel to

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are to relax regulation requirements, to commission vacant nursing and residential home capacity, to suspend the choice protocol -- that relates to an individual being able to have a choice, effectively, of which care home or facility to go to?

A. Yes.

Q. And then easement of social work hospital discharge assessments.

Now, just dealing with that, what we do not see there are any, and more broadly within this, any mention of any risks in there to care homes or patients -- residents in care homes; would you agree?

A. So this advice, of course, is not my policy area. I did not lead on this, I'm sure it's important to just clarify that today.

Q. Of course.

A. I think that this was very early thinking from the NHS, understandable in the circumstances, knowing that they were in a very difficult position with the reasonable worst-case scenario, knowing what they knew at the time around what was coming their way in terms of demand for, you know, acute healthcare. Within this, then, in answering your question, you know, there is limited, in terms of statements around the adult social care sector, but of course, that was then quite quickly where, as

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protect the 69 people they have the new patients should be either isolated or tested. They are also concerned that no testing is also available for staff who are ill."

That comes up, and if I can go back to page 1, please, and what we -- what -- we're asked initially if Public Health Wales, who the Public Health Wales contact would be, were they involved in this?

A. They were involved. They were involved because at that time we were very committed to producing discharge guidance that would support care homes.

Q. Thank you. If I can scroll up to the top, please. What you have to say about this, and it's progressed on to a conversation about symptoms as well, is you say:

"I don't think we can say do not admit with symptoms as the health service will collapse within a day ..."

And you say:

"... wouldn't this be self isolation and PPE? [And you're] Happy to discuss."

So, at this point, the overarching priority from your perspective is to discharge individuals because otherwise the healthcare system may well collapse, if you're met with those sorts of objections; is that right?

A. So this was a very difficult time for families, for

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1 loved ones. We had very clear advice, medical,
2 scientific, that we could safely discharge from
3 hospitals to care homes, but not without having, as I've
4 mentioned here, some, you know, safeguards in place to
5 protect people, you know, as I've highlighted, PPE and
6 self-isolation.

7 **Q.** Thank you. And in relation to those with symptoms, we
8 see that there was indeed guidance in relation to
9 self-isolation and individuals wearing PPE were there to
10 be a Covid-positive patient discharged.

11 But in relation to those individuals who may not
12 have been presenting with symptoms, there was no such
13 guidance.

14 **A.** Well, the advice at that time, and that's important to
15 look, in terms of the history, then, of -- you know, the
16 very complex history of asymptomatic, symptomatic, you
17 know, the advice at that time was that -- for
18 asymptomatics, was that we didn't need to do anything at
19 that particular point in the cycle of Covid-19.

20 **Q.** So at that point --

21 **A.** Yes.

22 **Q.** -- what you're saying is that the advice was that there
23 was no concern in relation to asymptomatic infection or,
24 more to the point, transmission?

25 **A.** And as we see it develop, we see that change over the
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1 that was -- you know, the prospects of, you know,
2 hospitals being overrun -- and it wasn't just about
3 protecting hospitals. That was about protecting life.
4 So these were very, very difficult judgements and calls
5 to be made.

6 And, you know, anyone affected by that -- you know,
7 I've always felt very deeply, and my condolences to each
8 and every one affected during the pandemic, but I think
9 that, you know, when we look back now, potentially
10 that -- as we term it, as we often use jargon of
11 "step-down facilities", I think that would be a really
12 good thing going forward.

13 So the earlier we could introduce that, I think,
14 that, to me, is a real learning point from this
15 experience.

16 **Q.** And turning to testing, and prioritisation of testing --

17 **A.** Yes.

18 **Q.** -- because at various stages there was scarcity of
19 testing and prioritisation had to take place,
20 Professor Khaw told the Inquiry that Public Health Wales
21 did not have access to the number of hospital discharges
22 to care homes, because they didn't have access to that
23 data source.

24 Now, they were also, at that point, advising on
25 testing and allocation of resources; is that right?
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1 next, I would say, six to eight weeks.

2 **Q.** I'm going to return back to the issue of asymptomatic in
3 due course, but do you now consider that there ought to
4 have been guidance in place -- looking -- and, again,
5 looking back in hindsight, I appreciate, from your
6 perspective, but also looking to the future -- to
7 isolate all admissions from hospitals as a precaution?

8 **A.** I think it would be very difficult to say today that at
9 that moment in time there should have been a very
10 different approach based upon the medical and scientific
11 advice we had, but of course, I mean, as part of this
12 process, I'm always keen to see what we could learn and
13 do differently. And I think when you come on to
14 asymptomatic, there may be some comments that might be
15 helpful reflections that I can make.

16 **Q.** Thank you.

17 Now, in terms of those care homes that may not have
18 been able to isolate, because, of course, different care
19 homes have different capacities and capabilities, ought
20 there to have been consideration of isolating those
21 residents in other settings, as became later the
22 position, as of around 29 April, when step-down was
23 introduced?

24 **A.** Well, certainly at the time, you know, as I've mentioned
25 already, it was a very difficult period for everyone
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1 **A.** Well, at that point they would not have had that
2 information, indeed.

3 **Q.** No. But they were the ones who were also advising on
4 it --

5 **A.** Mm.

6 **Q.** -- and how to use the tests that were available?

7 **A.** Yes.

8 **Q.** Should -- ought that information have been provided to
9 Public Health Wales at the time to inform that advice?

10 **A.** Well, I think it would have been better to have that
11 information available.

12 That information would have been held, I believe, at
13 a local health board level. And indeed, there was
14 modelling, then, undertaken retrospectively quite
15 quickly, and I know that, for example, the NHS assisted
16 in that modelling and that was shared with partners.

17 **Q.** And you'll be asked further questions about capacity in
18 due course in relation to hospital discharges, but
19 certainly with regard to those data flows, that's
20 something that, would you agree, needs to be put in
21 place, if it has not already?

22 **A.** Yes, the data flows around social care certainly have
23 improved since the pandemic, from our learning, but
24 there is no doubt that that data and information was
25 a very weak area that did not help us at the beginning
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1 of the pandemic.

2 **Q.** And it wasn't until 24 March, moving slightly towards

3 now, that Public Health Wales were asked for advice, to

4 provide a letter, it's gov guidance essentially, to the

5 care home sector in relation to accepting admissions or

6 returning residents, those residents that had been taken

7 to hospital and then were set to return to their care

8 homes.

9 **A.** Yeah.

10 **Q.** So at the time of the framework of actions, obviously

11 sometime before, is it right that there was not yet any

12 guidance in place for those care homes?

13 **A.** Well, those care homes would already have standard

14 guidance around infection prevention controls. The

15 Public Health Wales, to their credit, also had set

16 up a -- what I'll term a kind of a national contact

17 centre, as well, for care homes, care home providers, to

18 be able to contact, so it wouldn't be that they would be

19 operating in a system where they wouldn't be used to

20 having -- and they have advice and standard procedures

21 around infection prevention controls.

22 Obviously, Covid, as we know now, was a different

23 type of virus, as we journey forward.

24 **Q.** Indeed. And obviously the framework was set out on

25 the 12th.

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1 some respects --

2 **A.** Yes.

3 **Q.** -- which individuals were the correct individuals in

4 terms of what responsibilities and roles they held, and

5 frustrations, in short, becoming evident in relation to

6 progressing guidance, progressing advice for the sector.

7 Is that a fair summary?

8 **A.** It is a fair summary, and one of my learning points here

9 on reflection is, you know, if we were starting again,

10 would be to really ensure those points were clarified

11 and I think, as we journeyed through the pandemic there

12 is evidence that we did improve that communication and

13 flow between those -- us as partner organisations.

14 **Q.** Now, certainly, frustration is evident on your

15 director's behalf --

16 **A.** Yes.

17 **Q.** -- in relation to the speed and pace at which Public

18 Health Wales were working and operating in relation to

19 guidance. Can you provide a little bit more insight

20 into that?

21 **A.** I think, depending where your questions go next, and

22 I don't want to pre-empt, but I think there were

23 critical points where we probably found ourselves in

24 either a misunderstanding or different position, but

25 you're right to say that there were, at times,

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1 **A.** Yes.

2 **Q.** And then this -- we're talking now about 24 March.

3 **A.** Yes.

4 **Q.** By that -- I'm sorry, 13 March, and now we're talking

5 about 24 March.

6 But by this stage, consideration had not actually

7 been given, had it, to care home-specific advice in

8 relation to Covid and the discharge policy?

9 **A.** No, care home -- and that was the advice that I wanted

10 to see.

11 **Q.** Indeed.

12 **A.** Yes.

13 **Q.** Why was there that delay?

14 **A.** I think, you know, in hindsight, difficult to give

15 a precise answer today. My experience was just the

16 sheer speed of things that were happening at that

17 particular time. But as I say, you know, care homes did

18 have advice and had advice available to them at that

19 time, so it wasn't that they were operating in a total

20 vacuum to standard operating procedures.

21 **Q.** Now, in terms of your communications and collaboration

22 between the various agencies between your directorate

23 and Public Health Wales, you and, indeed, Public Health

24 Wales speak of various challenges that were encountered

25 with confusion as to who held what responsibility in

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1 frustrations, I'm sure on both parts, but equally, we

2 were, you know, from my seat, as lead around social

3 care, I was just really keen that we could get

4 information, good information, quality information, out

5 to support the sector as soon as possible.

6 **Q.** And we see one example of that, actually, in relation to

7 the hospital discharge guidance, and if I can just call

8 up INQ000336353, please. And if we can go down to the

9 second paragraph, initially what we see here is:

10 "I am trying to progress this with [Public Health

11 Wales] ... not getting very far -- it's extremely

12 frustrating."

13 Obviously a conversation is then referenced with you

14 speaking to different individuals also.

15 And then what we have is:

16 "I heard separately yesterday that the Chief

17 [Executive] of [Public Health Wales] is planning to

18 write a joint letter with someone from [Welsh

19 Government] WG (I assume Albert) [you] to all care home

20 providers covering admissions and a range of other

21 issues."

22 They are trying to work out whether it is the

23 guidance they have their team working on or there's

24 a risk of duplication.

25 And so this is an example of the issues that your

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1 team and, indeed, on -- we've heard some evidence, as
 2 I say, from Public Health Wales were dealing with at the
 3 outset, but do you accept that those sorts of issues
 4 could have had a real impact upon those care home
 5 providers who were struggling in the absence of specific
 6 sector guidance?

7 **A.** I think for care home providers, one of the real
 8 learning points through the pandemic was for them, and
 9 their staff, they were a real credit to the profession,
 10 the things that they did. They went above and beyond.
 11 There were many really good illustrations, and I think,
 12 you know, without a doubt, you know, this is a matter of
 13 days, sometimes, but from my perspective the earlier, as
 14 I've said earlier, the learning from this is the
 15 earlier, if you could bring everything forward, you
 16 know, that would be a good thing as a learning point for
 17 any future pandemics that we may face.

18 **Q.** And in terms of future pandemics, has there been any
 19 thought given as to how you'd approach that in the
 20 future to ensure better working, better delineation of
 21 roles, and good communication so that you can get
 22 guidance out swiftly to a sector that needs it?

23 **A.** Yes, indeed, and of course, the only caveat I would say
 24 to that, which there is one, is that a lot of people
 25 I worked with during the pandemic, they have already

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1 that you say in your witness statement at paragraph 308.
 2 And it's dealing with the issue of testing.

3 **A.** Yes.

4 **Q.** You say:

5 "It was clear that if discharges were not made,
 6 hospitals would not be able to function effectively ..."

7 And we've seen that already from your emails at
 8 an earlier stage. And you said:

9 "In the absence of advice to the contrary from
 10 health experts and evidence regarding asymptomatic
 11 transmission, while testing of all patients would have
 12 been preferred, without sufficient testing capacity, it
 13 was not possible."

14 So what you're saying here is: ideally it would have
 15 been good to have tested everybody but insufficient
 16 capacity; is that right?

17 **A.** Well, I think there are two points to clarify here. One
 18 was the science and the medical advice was still
 19 indicating very strongly around who to test and who not
 20 to test, and what was required.

21 My professional view, of course, is that the earlier
 22 we can use testing to build confidence -- get a clearer
 23 picture, manage Covid-19, would have been my preferred
 24 choice, but of course, you will see and you will know
 25 this very well, I'm sure, but from my perspective, the

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1 moved on. So the learning about the experience of the
 2 pandemic, I think, from this Inquiry will be invaluable
 3 to us all in terms of what we do in preparedness for the
 4 future.

5 **Q.** Now, just dealing with some evidence that we've heard
 6 from Public Health Wales, they explain that in relation
 7 to this, there should not have been any confusion
 8 because as far as they were concerned, they had
 9 a clearly identified incident director rota, and that
 10 rota was available to the Welsh Government. Was that
 11 rota available to you and your team within the Welsh
 12 Government?

13 **A.** Certainly, I can't recall seeing that rota myself,
 14 personally.

15 **Q.** Now, if I can turn then, please, to slightly later, on
 16 2 April, the UK Government published its guidance on the
 17 admission and care of residents in care homes. Public
 18 Health Wales's guidance was not published until 8 April.
 19 Do you know why there was that delay, that further
 20 delay?

21 **A.** Well, that's very much on the point that you've just
 22 been questioning me on. It's to do with, you know,
 23 working through the detail, points of clarification,
 24 and, you know, the guidance was then issued on 8 April.

25 **Q.** And if I can just touch now in relation to something

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1 testing capacity takes some considerable time to really
 2 allow us, then, to do that wider-base testing that
 3 begins to emerge in the May and June period.

4 **Q.** Indeed. What I want to focus in on, if I may, with you,
 5 is, in terms of your view that testing would have been
 6 preferable, but you didn't have sufficient testing
 7 capacity, at this time, firstly was the decision not to
 8 test made, effectively, on scientific advice that you
 9 shouldn't test or was it made on the basis that it would
 10 have been desirable to, but we don't have capacity so we
 11 have to prioritise?

12 **A.** It was made based upon the medical and scientific
 13 advice.

14 **Q.** And so is that your view in hindsight, effectively: it
 15 would have been preferable to have tested but we didn't
 16 have capacity?

17 **A.** That would be my view in hindsight. It would be.

18 **Q.** Thank you.

19 Now, in terms of further hospital guidance that was
 20 published on 7 April, Professor Khaw again told the
 21 Inquiry that PHW was not consulted and it would have
 22 been helpful to, because of course it involves their
 23 roles and responsibilities. Do you know why they
 24 weren't consulted by that point?

25 **A.** Could you just repeat that question, please?

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1 Q. Of course.
 2 So there was hospital discharge guidance that was
 3 produced by the Welsh Government -- that's why I'm
 4 asking you about it, as opposed to the NHS --
 5 A. Yes.
 6 Q. -- dated 7 April. And Professor Khaw explained that
 7 Public Health Wales was not consulted in relation to
 8 that. Do you have any understanding as to why that
 9 would have been?
 10 A. Well, the guidance that published around 7, 8 April, was
 11 guidance that -- certainly my understanding was that
 12 Public Health Wales had been sighted on that guidance.
 13 Q. Would you have expected it by that point? Were those
 14 earlier issues about communication ironed out at this
 15 stage or were they still there?
 16 A. Well, in the early -- I think the communication issues,
 17 possibly there was some point -- you know, between the
 18 March and April period, but by May we begin to see that
 19 among forward. But certainly on that guidance -- and
 20 I'm happy to be corrected afterwards -- but my
 21 understanding is I think Public Health Wales were
 22 sighted on that particular guidance. But that, again,
 23 may reflect the different communication channels within
 24 Public Health Wales.
 25 Q. Professor Khaw explained that, from his perspective, the

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1 had met I think on the 14 April date, and had certainly
 2 from SAGE and others begun to understand more around
 3 discharge into care homes from hospitals.
 4 On 15 April the policy changed in England, an
 5 announcement to test all discharges into care homes from
 6 hospitals. And at that point -- both myself and the CMO
 7 wanted a change in policy. So this relates to that
 8 request. That request went in an email on the 15th and
 9 then was followed up in a further email from the CMO's
 10 office by Dr Marion Lyons on the 16th. So that's what
 11 this relates to at that point.
 12 Q. My question in relation to it is just that these
 13 problems were continuing. I'm going to turn to the 15th
 14 guidance in a moment, but this is an indication that
 15 still, at this point, those issues are continuing?
 16 A. I think that's absolutely correct, and I've acknowledged
 17 earlier we would have wanted to do that differently.
 18 But I think on this occasion, just to say from a policy
 19 perspective, I think we were clear on the 15th, and
 20 I think we were clear on the 16th.
 21 Q. Now, turning to the policy implemented on 15 April, as
 22 you say to test all discharges from hospital, that took
 23 some time, actually, to be implemented, with the
 24 guidance being produced effectively two weeks later, on
 25 29 April.

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1 policy decisions of the Welsh Government remained quite
 2 unclear for some time. And that was escalated up the
 3 chain to you at one stage, do you recall, by way of an
 4 email?
 5 And if I can -- I can call that up for you if it
 6 would assist. It's INQ00499632.
 7 And what we see -- it's under the words
 8 "A few points", about a third of the way down, first
 9 bullet point:
 10 "Several references below to not having clear
 11 steer/instruction from [the Welsh Government] ... been
 12 provided in e mails to PHW from both Marion and I. It
 13 was reiterated at the meeting this morning. However,
 14 Andrew kept saying that from a meeting he'd attended
 15 yesterday this was not Vaughan's position."
 16 So were you reliant at that point still on just
 17 discussions and emails as opposed to formal structures
 18 and communications?
 19 A. So the earlier question related to a different
 20 guidance --
 21 Q. Yes.
 22 A. -- which I'm pretty sure they had sight of.
 23 Q. Yes.
 24 A. This relates to a change in our knowledge around testing
 25 on discharge. You will have seen Tactical Advisory Cell

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1 A. Yes.
 2 Q. Now, it's been accepted that there was obviously that
 3 delay by the Welsh Government. Why was that policy not
 4 implemented immediately, rather than waiting for updated
 5 guidance, which obviously took some time?
 6 A. Yeah, and I think the first thing to say is, look, you
 7 know, we are deeply apologetic for the length of time
 8 that that took. I know that I was personally concerned
 9 at the length of time at the time. And, you know, in
 10 terms of the experience for anyone who suffered during
 11 that time, you know, I, on behalf of Welsh Government,
 12 are deeply sorry for that.
 13 The reasons, I think, are, to me, related to
 14 actually Public Health Wales, our communication with
 15 them at the time. Clearly, as I've mentioned, I think
 16 we -- that's a learning point for us all. But we were
 17 asking Public Health Wales around, you know, testing
 18 capacity, which they were, in a sense, the custodians
 19 of. So I think there was -- there were questions that
 20 we needed to answer, to understand, to work through, and
 21 some of that took a lot longer than I certainly would
 22 have liked to have seen.
 23 Q. My question is, really, why did you just simply not
 24 implement that policy, rather than wait
 25 -- (overspeaking) --

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1 A. And I did try to answer, but maybe not as clear as
 2 I could have been --
 3 Q. No, that's all right.
 4 A. -- so my apologies.
 5 I think that's because we needed to understand about
 6 testing capacity and some of the wider -- and it wasn't
 7 just one question we were answering. I think that's why
 8 we were able to go ahead with the discharge and get that
 9 completed from the Welsh Government perspective. But
 10 we -- but I was interested at that time around global
 11 testing of care homes, for example, so I was looking at
 12 potential wider protective features. And I think --
 13 Q. We're going to move on to that -- (overspeaking) --
 14 A. -- by putting things together that maybe didn't help get
 15 the clarity as quickly as we should have done.
 16 Q. And when do you say you had the capacity to test all
 17 patients on discharge? Can you recall when that was?
 18 A. Well, in terms of the capacity to begin to do the
 19 testing, that was really from the May, the May 15/16
 20 period into June.
 21 Q. So I'm talking just about discharge at the moment --
 22 A. Discharge -- no, we were able to do that then, we were.
 23 Q. Now, I want to move on now to ask about the move to
 24 asymptomatic testing within care homes, if I may.
 25 Initially, obviously, there was the Easter 6 study

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1 A. Yes.
 2 Q. And so that was to apply to -- all residents and staff
 3 would be able to get access to a test regardless of
 4 whether they had symptoms, and it was the 2 May in Wales
 5 that there was an announcement that there would be
 6 further testing in care homes but at that point it was
 7 symptomatic individuals and they would be combined with
 8 isolation pending results, and then testing,
 9 effectively, where there was somebody with symptoms of
 10 Covid, but also the care home had in excess of 50 beds.
 11 So the larger care homes; do you recall that?
 12 A. Yes, I do recall that very clearly.
 13 Q. So at that stage, there's not a rollout to all homes of
 14 asymptomatic testing. Why was there a delay?
 15 A. Well, I wouldn't say there was a delay. The decision at
 16 the time based on the medical advice and the science was
 17 still indicating that we did not need to move to testing
 18 of all asymptomatic, and that is again, I've mentioned,
 19 learning points, the question going forward is, you
 20 know, at what point should you begin to test for
 21 asymptomatic? You may be coming on to this, but we then
 22 see the science change in certainly that second week in
 23 May, where we have, I think on 12 May, around that date,
 24 a SAGE meeting and advice coming through which clearly
 25 indicates, in the language I think that was used at the

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1 that was conducted by Public Health England that raised
 2 and concluded that symptoms were poorly predictive of
 3 infection, and therefore a poor control -- trigger for
 4 control measures. And that's plainly speaking to
 5 potential asymptomatic infection there.
 6 Now, when were you first made aware of that study?
 7 Do you know?
 8 A. It would have been, you know, quite quickly, because the
 9 team were picking up on things. So, as soon as that
 10 started circulating in SAGE papers, et cetera, I was
 11 alert to that.
 12 Q. Thank you. And it was published on 18/19 April, so
 13 that -- (overspeaking) --
 14 A. Yes, that would feel about right.
 15 Q. Indeed.
 16 And if I can just ask you in relation to this, it
 17 appears that the decision within the Welsh Government to
 18 test all patients, asymptomatic residents and staff, was
 19 prompted by the UK Government's announcement; is that
 20 right?
 21 A. I think, yeah, there was a number of times where
 22 UK Government, based upon SAGE, had moved, and we would
 23 follow on that advice.
 24 Q. And so that announcement from the UK Government came out
 25 on 28 April, if that assists.

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1 time, the value in testing asymptomatic. And therefore,
 2 the policy changed in Wales around that mid-May point,
 3 around 14, 15 May.
 4 Q. What I'm really asking about is the fact that obviously
 5 the UK Government, nonetheless, announced this on
 6 28 April --
 7 A. But their policy, you'll recall, I'm sure you will --
 8 yeah.
 9 Q. I was going to say, it evolved, effectively, but what we
 10 saw from the Welsh Government was 2 May, that expansion,
 11 but it was not until 16 May that the Welsh Government
 12 then implemented and announced all testing for
 13 asymptomatic care residents --
 14 A. But I could stand corrected on this, but in the meeting
 15 of 30 April, my understanding was that the announcement
 16 on 28 April from the UK Government wasn't the position
 17 that was being held. So that all asymptomatics, my
 18 understanding was that that was not the position of the
 19 UK Government on the 30th.
 20 Q. As I say, it evolved over the next few days.
 21 A. Yes.
 22 Q. But it was certainly the case that the UK implemented it
 23 before Wales, and that's why I'm asking about the delay.
 24 A. Well, you know, and I've answered that question
 25 I believe, I hope I have, and I'm certainly happy to go

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1 back over it, but it was where the science and advice
2 changed around 12 May that was critical for the Welsh
3 change in the, in the guidance around the testing.
4 **Q.** Now, I want to just turn now, if I may, to experiences
5 of care homes where they had patients discharged to them
6 who did, indeed, demonstrate symptoms of Covid and later
7 were to test positive for Covid.

8 If I could just bring up, please, the Every Story
9 Matters record, and that's INQ000587564, page 65.

10 Just to ask you about the experiences, as I say, of
11 some care homes. So here we can see, if I can go down,
12 I'll just choose the one mid-way down actually:

13 "The hospital would say they didn't have it."

14 So that's a reference to an individual being
15 discharged being told they did not have Covid.

16 And:

17 "Then when they literally came through the door to
18 us and we would test them and they would be positive for
19 Covid. I believe the hospitals couldn't manage the
20 amount of patients they had, so it was easier for them
21 to just let the residents go back to their care homes
22 and leave the carers and the nurses to deal with them."

23 Now, obviously, putting aside the issue that a test
24 on one day can give a different result, these are themes
25 that recur in relation to discharge of patients.

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1 tests, but then those tests would arrive late, often
2 sadly after their resident had died. Were you aware of
3 those issues?

4 **A.** I was certainly, you know, in that scenario, that is
5 quite a dreadful scenario. So I think that has impact
6 for us all. I was aware of many illustrations during
7 the pandemic of times where things were difficult,
8 challenging, and around, sometimes, test results coming
9 back, as well. So although there was a high rate of
10 test results coming back, it wasn't a hundred per cent,
11 and so those issues were real and challenges that we
12 were facing.

13 **Q.** And what, if anything, did the Welsh Government do in
14 response to that, was there an attempt to expedite tests
15 and things of that nature?

16 **A.** Oh yes, very much so. Very active indeed.

17 **Q.** And we've also heard that when those tests were
18 received, they were unable then to be repurposed for
19 anyone else. Now, this was at a point where there was
20 said to be a scarcity of testing, so every single test
21 mattered or counted. Why was that the policy?

22 **A.** Well, testing wasn't my policy area, I'm afraid. I know
23 there will be others who are better placed to give you
24 a good response on that.

25 **Q.** Of course, thank you.

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1 That also, perhaps, fed into those concerns that the
2 overriding concerns of the Welsh Government were the --
3 preventing the collapse of the NHS, and very much
4 secondary, if not much further down the list, was the
5 care sector. What do you say in relation to that?

6 **A.** Yeah. Well, I think some of the experience were --
7 experiences that we would not have wanted to see happen,
8 and I take the care home experience here.

9 Certainly from my role, and my directorate, you
10 know, I would say there were lots of illustrations where
11 we were actively supporting social care, engaging with
12 the social care sector, and also advising Welsh
13 Government, whether that was the CMO or other parts of
14 Welsh Government, in relation to the importance of, you
15 know, ensuring that the social care sector was well
16 supported at this time.

17 And I think, you know, there is lots of evidence of
18 the role of my directorate in that position.

19 **Q.** And then also, just if I may, on the testing, then, that
20 did take place in care homes of people with symptoms --

21 **A.** Yes.

22 **Q.** -- so before asymptomatic testing is rolled out and
23 testing is limited to just those individuals with
24 symptoms. And we've heard previously from Ms Hough,
25 a care home owner and nurse, that they would request

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1 If I can move, I appreciate it's not your policy
2 area, you cover it to quite some degree in your
3 statement and I appreciate the reasons why, but what you
4 do say in relation to testing specifically, and this is
5 where you are involved, is that -- and this is more
6 broadly across the sector:

7 "In the early stages it was ... difficult to be
8 clear about who was making what decisions for testing
9 and where, and therefore difficult to ensure social care
10 testing policy was optimal ..."

11 So in that respect, why was there that lack of
12 clarity of who was responsible for testing, testing
13 policy? Because as we see, those problems appear to
14 persist nearly all the way throughout 2020.

15 **A.** I think in the early stages, you know, my assessment is
16 that, you know, this was new, it was a different type of
17 challenge, so that between ourselves, Public Health
18 Wales and others, it was difficult to know who was
19 leading. From conversations I had with the Director
20 General, I know that he took steps then, you know, for
21 example he appointed Jo-Anne Daniels to lead, and from
22 that point onwards I think I have seen, you know, I've
23 seen a considerable change in terms of understanding and
24 grip, as well.

25 **Q.** Can we talk about a specific example, please, and that's

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1 in relation to domiciliary carers.

2 **A.** Yes.

3 **Q.** And it's an example that you provide, and what we can

4 see is that, in Wales, the weekly testing of all care

5 home staff was rolled out on 15 June 2020. Domiciliary

6 carers were not a part of that rollout or that

7 programme; is that right?

8 **A.** That is indeed correct.

9 **Q.** And you certainly, within your directorate, had

10 considered their inclusion. Had you considered their

11 inclusion prior to the rollout or was it something that

12 took place afterwards?

13 **A.** No, we were considering domiciliary care workers very

14 early on. I've got, you know, clear illustrations where

15 I and others were raising issues around domiciliary care

16 early in the pandemic.

17 **Q.** Indeed, in a paper, a written case in support of testing

18 domiciliary carers was provided to the government

19 testing cell on 10 July of 2020 from your directorate.

20 **A.** Yes.

21 **Q.** But it was not considered. Do you know why it was not

22 considered?

23 **A.** I do not know why it wasn't considered but I know it was

24 re -- it was brought back to their attention.

25 **Q.** And you continued, you say, in your statement, to press,

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1 **Q.** So it's quite late then?

2 **A.** Yes.

3 **Q.** You submitted, as I say, the initial paper on 10 July,

4 resubmitted it on 28 July. You set out the rationale as

5 you've described, effectively as you've summarised now.

6 It was also noted that there was a clear disparity

7 between that testing available within social care

8 settings, care homes and the like, that was not

9 available for domiciliary care.

10 And within that advice, it's set out that, in

11 regards to that disparity, there was no clear rationale

12 for that disparity. Was that your view?

13 **A.** Can you just repeat that again? I just want to be

14 clear --

15 **Q.** -- (overspeaking) -- I probably confused you.

16 Sorry, what I was saying was, within your written

17 case, it's set out that there was no clear rationale as

18 to why there was a disparity between testing within --

19 of all care home staff that was rolled out, and

20 domiciliary carers. So it's that disparity. And there

21 being no proper justification for it.

22 Was that your view at the time?

23 **A.** Well, I would actually say no. My view was that

24 domiciliary care workers should be tested for the

25 reasons that I've set out, but the decision back was

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1 and it was resubmitted a couple of weeks later, on

2 28 July.

3 And in relation to that, if I can just set it out,

4 what was the pressing rationale to your -- in your view,

5 as to why domiciliary carers ought to be tested at that

6 point?

7 **A.** So my rationale with this -- you know, obviously I'm not

8 a doctor, I'm not a scientist, but my rationale was

9 that -- and there's this long answer and a short

10 answer -- I'll go for the short answer and see if that

11 helps -- is that, you know, domiciliary care workers are

12 mobile between different dwellings. They're going in

13 a different people's homes, coming into contact with

14 lots of people. And my issue was also about protecting

15 them, of course it was, but it was also recognising that

16 they worked with very vulnerable people, and it was

17 about protecting those vulnerable people first of all.

18 So I felt that a testing regime -- and that's why,

19 personally, when -- one of the big moments in the

20 pandemic for me was the introduction of lateral flow

21 devices. And it was at that point that domiciliary care

22 workers were part of that testing regime.

23 **Q.** Indeed. And that's not, however, is it, until

24 23 November 2020?

25 **A.** No, it's not.

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1 based upon the medical, scientific advice.

2 There was all sorts of analyses around the

3 percentage of domiciliary care workers versus the

4 population of people infected. I think not seeing them

5 as entering closed settings. But there will be others

6 who will be better placed on the side of those that were

7 offering that advice.

8 My constructive -- and purposeful challenge was

9 that I felt that domiciliary care workers, and indeed,

10 one of my learning points is -- that I would like to

11 see, in the future, domiciliary care workers seen in the

12 same capacity as we would view the importance of testing

13 care home workers.

14 **Q.** You've referred to scientific advice in relation --

15 **A.** Yes.

16 **Q.** -- to the testing of domiciliary carers. Do you know if

17 there was sufficient testing capacity at that time?

18 **A.** Well, I wouldn't have been able to answer that question

19 at that time. Testing was improving, the scale and

20 scope. So, you know, again, others would be better to

21 say, "Yes, we had capacity" or "No, we didn't". I felt

22 by that period we probably had more capacity than we

23 certainly had at the earlier stages.

24 I don't believe it was just a -- I don't believe it

25 was just a capacity decision, however. I think it was

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1 the decision from, you know, Technical Advisory Group
 2 and others, was that they did not need to be tested.
 3 **Q.** Thank you. Now just dealing with one of the other
 4 rationales that was put forward, or the other arguments
 5 for testing, you had evidence within your directorate of
 6 domiciliary care packages refused by users because of
 7 their anxiety over potential transmission by those care
 8 workers entering their homes; is that right?
 9 **A.** Yes.
 10 **Q.** And do you accept that that in turn could potentially
 11 pose risks to those disabled people in terms of having
 12 their needs met, if their anxiety was overriding the
 13 actual provision of that care?
 14 **A.** Indeed.
 15 **Q.** Did you or your department within the directorate make
 16 any further enquiries or take any action to seek to
 17 research those people that were in receipt of
 18 domiciliary care?
 19 **A.** That would be the responsibility of the local
 20 government, those that are providing the delivery and
 21 the care.
 22 **Q.** Was any guidance or information provided to local
 23 government?
 24 **A.** I don't believe we provided any information, nor do
 25 I think we were asked for any information.

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1 absolutely tremendous, but also had impacts. They were
 2 isolated. They had other hardships, financial. But we
 3 were very mindful throughout the pandemic around support
 4 to unpaid carers.

5 Unpaid carers were able to access PPE, there was
 6 criteria that was developed to access PPE. And also,
 7 there was other supports that we put in place, you know,
 8 through hardship funding, working with some of our key
 9 partners to get respite services and support in other
 10 ways.

11 So they weren't -- for me, they weren't -- I think
 12 what was your word? It was un ...?

13 **Q.** I'm not sure -- well, it would certainly have been
 14 -- (overspeaking) --

15 **A.** Unseen, or --

16 **Q.** -- being considered --

17 **A.** They were definitely being considered during the --

18 **Q.** But specifically in relation to testing is really what
 19 was my question.

20 So were they, during this period, being actively
 21 considered in relation to potential rollout of routine
 22 testing in the same way that you were looking at
 23 domiciliary carers?

24 **A.** There were a lot of groups that we were looking at in
 25 terms of when we should be able to test, and I think

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1 **Q.** Now obviously at care homes, that attracted
 2 a significant amount of attention, and indeed, and staff
 3 and ingress routes and those sorts of policies, but was
 4 this an example of domiciliary care being a bit of
 5 a blind spot, the fact that it was not being prioritised
 6 in the same way?
 7 **A.** No, I don't think it was a blind spot, because then
 8 I would -- you know, as I say, obviously we'd promoted
 9 and had the discussion as we've just described around
 10 testing but we were providing PPE and other support. So
 11 whilst I've answered the question in relation to testing
 12 and individuals, it was quite clear that we were
 13 supporting dom care workers as we would do the other
 14 workforce, especially around personal protective
 15 equipment.
 16 **Q.** You've explained that obviously all of these people that
 17 are being cared for have vulnerabilities in relation to
 18 Covid?
 19 **A.** Yes.
 20 **Q.** And potential risks in terms of infection. What about
 21 unpaid carers? Were they being considered actively
 22 during this time? Because they are obviously also
 23 providing care to individuals who may be at greater risk
 24 of infection or more serious consequences of infection?
 25 **A.** Yes, I mean unpaid carers during the pandemic were

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1 that was again what I mentioned, that kind of lightbulb
 2 moment, which, you know, for me, was so important.
 3 I think the development of the lateral flow devices then
 4 opened up the ability to do much more around supporting
 5 unpaid carers and others around testing.

6 **Q.** Indeed, but that was to the general population in
 7 November.

8 **A.** Yes.

9 **Q.** What I want to know is whether, in effect -- was there
 10 a specific time at which unpaid carers were specifically
 11 considered for potential routine testing?

12 **A.** Well, I was -- I wasn't involved in all of the testing
 13 decisions, as I've mentioned. I didn't lead on testing.

14 But I know that my policy officials were looking at
 15 number of groups around testing, and I know that they
 16 were also thoughtful and mindful to raising issues
 17 around where we support and how we support our unpaid
 18 carers.

19 **Q.** But am I right that you cannot actually assist us on
 20 whether or not unpaid carers were being
 21 considered -- (overspeaking) --

22 **A.** Others will be better placed on that, I'm afraid. My
 23 apologies.

24 **Q.** And just to complete the chronology, it was in November,
 25 effectively, that, because of your concerns, you say in

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1 your statement, over testing, and coordination of
 2 testing and responsibility for testing, and those issues
 3 with papers not being considered and so on, that you had
 4 discussions more broadly with Public Health Wales, the
 5 Chief Medical Officer, the Welsh Government Testing
 6 Senior Responsible Officer, to try to seek a more
 7 coordinated group, and that resulted in the Social Care
 8 Testing Infection Prevent and Control group in November
 9 of 2020 which --

10 A. Yes, I set that up.

11 Q. Indeed. And you chaired it initially?

12 A. Yes, I did.

13 Q. Thank you. Now, if I may turn to a new topic, and that
 14 engages the role of Care Inspectorate Wales.

15 A. Okay.

16 Q. And the cessation of inspections within Wales. Now,
 17 within your statement you explain that you were
 18 supportive of Care Inspectorate Wales' decision to
 19 suspend those routine inspections, and we've heard
 20 evidence from Care Inspectorate Wales as to why that
 21 was. But that you were reassured that safeguarding
 22 issues and other concerns would continue to be
 23 investigated.

24 Now, looking back now, on that decision, and just
 25 taking your perspective, putting aside those of Care

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1 challenge. I think at the time, you know, we look back
 2 and we know that care homes were isolated, but I think,
 3 for me, you know, what reassured me during that period
 4 was that, you know, Care Inspectorate Wales weren't
 5 operating away from the sector; they were operating to
 6 the sector. So they had their check-in weekly calls,
 7 there was lots of communication. And I was regularly in
 8 touch with Care Forum Wales, for example.

9 There were a lot of contact points about, you know,
 10 standards of care. You know, it was very active around
 11 promoting visiting, balancing the rights to protect
 12 individuals with the rights of people to see their loved
 13 ones. So I think our contact around care homes and the
 14 environment was very lively, very active, with lots of
 15 partners. Obviously, I wouldn't be sighted on
 16 individual care homes but I know that where issues were
 17 raised, they were acted upon by Care Inspectorate Wales.

18 Q. Thank you. Now, if I may, I'm going to move now to
 19 visiting restrictions in care homes. That is an area
 20 that your department, indeed you were very heavily
 21 engaged in during the pandemic in terms of promulgating
 22 guidance.

23 And that first guidance on visiting in care homes
 24 was issued on 23 March 2020.

25 If I could just bring that up, please, it's

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1 Inspectorate Wales, do you still believe it was the
 2 right approach for Care Inspectorate Wales to suspend
 3 those inspections?

4 A. Well, I mean, obviously, it wasn't a decision for me to
 5 make, but I still do believe that was a balanced
 6 decision that Care Inspectorate Wales made.

7 Q. And did you, or anyone else, consult care home residents
 8 and their families about the suspension of those
 9 inspections -- (overspeaking) --

10 A. That would have been for --

11 Q. -- been for Care Inspectorate Wales?

12 A. Yes, it would have been.

13 Q. Now, a number of Core Participants, including Covid
 14 Bereaved Families for Justice Cymru, in their corporate
 15 statement, have raised concerns about the suspension and
 16 general reduction of those inspections over the course
 17 of the pandemic. They are concerned that without
 18 regulatory oversight it's difficult to know whether
 19 their loved ones were provided with proper care or if
 20 there were any safeguarding concerns?

21 How were you assured about that care provided in
 22 Wales in the absence of inspections, as Chief Social
 23 Worker, and all of your responsibilities that your role
 24 involves?

25 A. Yes, you know, I think it's a great question, a great

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1 INQ000336332. Thank you.

2 And here we see a letter going out to the providers
 3 dealing with guidance for visits. And what we see
 4 within here are, effectively, that visits are going to
 5 be limited to essential visits only, I'm paraphrasing,
 6 but that's essentially what it amounts to; that
 7 non-essential providers or contractors such as
 8 hairdressers and builders, whoever it may be, could no
 9 longer enter. That also applied to professional
 10 visitors, unless it was essential.

11 A. Yes.

12 Q. Doctors and the like, health professionals.

13 Within the guidance you say you:

14 "... recognise the importance of relationships with
 15 family and friends in emotional wellbeing and cannot
 16 reinforce strongly enough the crucial role visitors can
 17 now take in ... [protecting] their family and friends by
 18 not visiting, while continuing to support emotional
 19 wellbeing in alternative ways."

20 You explain that this is going to be individual
 21 case-by-case basis, decisions to be taken by care home
 22 managers, those are who the requests should go to.

23 So that's where the decision making is taking place
 24 from your perspective; is that right?

25 A. Yes.

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- 1 Q. At the very local level --
- 2 A. Yes.
- 3 Q. -- within the individual care home?
- 4 A. Yes.
- 5 Q. You appreciated that there were going to need to be
- 6 sensitive discussions in regard to end-of-life care for
- 7 those residents. And that you'd hope that these
- 8 restrictions would be in place and undertaken for the
- 9 shortest possible period.
- 10 At that point in time, were you expecting these
- 11 restrictions to be a matter of weeks as opposed to
- 12 prolonging over more than a year, two years?
- 13 A. Certainly, at that stage, I never -- I wouldn't have
- 14 foresaw that we would have 14 versions of guidance for
- 15 visiting. So, you know, absolutely did not foresee it
- 16 being over that length of time.
- 17 But also, even at the very beginning, I was aware of
- 18 the importance of visits and contacts and wellbeing,
- 19 hence it wasn't a blanket approach. And also, I know
- 20 that we supported a number of, you know, tablets and
- 21 other digital material to try to help care homes and
- 22 loved ones keep in touch.
- 23 Q. And just dealing with the guidance that was promulgated,
- 24 as you say, a number of iterations?
- 25 A. Yes.

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- 1 know, given the length of time that had already occurred
- 2 between the beginning of, you know, that lockdown, the
- 3 23 March restrictions on visiting, and, you know, this
- 4 is where good working across partner organisations, we
- 5 were able to work, you know, Care Inspectorate Wales,
- 6 you know, held a group. A group itself doesn't achieve
- 7 everything, but within that group critical stakeholders
- 8 were able to really bring alive and make sure that we
- 9 could balance the rights of individuals.
- 10 Q. Thank you. I'm just going to deal with some of those
- 11 iterations, and as I say, they align broadly with what
- 12 restrictions may have been in the wider community.
- 13 So 1 June, when the Stay at Home message was changed
- 14 in Wales to one of Stay Local, at that point, there was
- 15 permitted outdoor visits and you sent -- your guidance,
- 16 at that stage, encouraged the facilitation of those
- 17 outdoor visits.
- 18 That was then followed up again in various
- 19 iterations.
- 20 Version 3 of the guidance came on 28 August. That
- 21 saw a move to permitting indoor visits, and that again
- 22 reflected a change in national restrictions. So they're
- 23 following the national restrictions broadly; is that
- 24 right?
- 25 A. Yes, broadly.

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- 1 Q. Each iteration of that guidance was developed within the
- 2 parameters of what the national restrictions were or the
- 3 local restrictions were at any given time; is that
- 4 right?
- 5 A. Yes, it is right, but there were points, for example,
- 6 the firebreak that took place, I think end of October,
- 7 beginning of November. You know, a reasonable excuse
- 8 was a visit to a care home where that was deemed to be
- 9 appropriate.
- 10 Q. Indeed. I'm going to move to some of the issues that
- 11 you had in the firebreak in due course but I'm just
- 12 concentrating, if I may, at the beginning of that
- 13 guidance and how it developed.
- 14 So on 27 May you met with the Older People's
- 15 Commissioner, Hélène Herklots, who we heard from
- 16 yesterday.
- 17 A. Yes.
- 18 Q. And you agreed at that point that guidance should be
- 19 co-produced in conjunction with the sector. Obviously
- 20 that's going to be more time consuming. Why did you
- 21 consider that to be important?
- 22 A. I think, you know, firstly, I think the Older People's
- 23 Commissioner played a very important role during the
- 24 pandemic. I was very grateful for advice and challenge.
- 25 I felt that at that stage it was really important, you

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- 1 Q. So what we've got there is the availability to speak
- 2 to -- to meet indoors. But by this stage you'd had
- 3 fairly significant correspondence, more broadly, from
- 4 both individuals who were subject to these restrictions
- 5 and their loved ones but also the Older People's
- 6 Commissioner with significant concerns being raised.
- 7 And what was your view at that stage?
- 8 A. Yes --
- 9 Q. So this is the August moving into September?
- 10 A. So August moving into September, those that took their
- 11 time to write, I was very grateful to them sharing their
- 12 stories and position, and I thank them for that. I know
- 13 it was very painful for them. But we were able then to,
- 14 I think, advocate for that balance, recognising the
- 15 rights of individuals to see their loved ones and to
- 16 balance risks. So we talk about dynamic risk
- 17 assessments, and certainly, for me, we were moving then
- 18 to, you know, indoor visits and without leading on too
- 19 far, because you may be going there on future questions,
- 20 you know, we did a range of actions that supported and
- 21 enabled visiting to take place.
- 22 Q. I'm just going to ask you, if I may then, about the
- 23 September local restrictions before we pause for
- 24 a break, and in relation to those, local -- the local
- 25 restrictions were introduced in various areas within

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1 Wales in response to rising infection rates.
 2 A number of those, of local authorities, decided,
 3 however, to cease all visits, so put a blanket ban,
 4 effectively, on visiting, at a point when, in terms of
 5 the more broader restrictions, outdoor visits were still
 6 permitted. So we see that in Caerphilly, for example.
 7 And those were, you explained, decisions taken
 8 typically in collaboration with the incident management
 9 teams and Public Health Wales.
 10 **A.** Yes.
 11 **Q.** But when you were aware of those effective blanket bans
 12 being put into place, what did you do, if anything?
 13 **A.** Well, I took action. Both myself and the chief
 14 inspectorate, Care Inspectorate Wales, wrote out to all
 15 local authorities across Wales. We were very clear in
 16 our expectation and supporting. We spoke with Welsh
 17 ministers and we spoke with key stakeholders.
 18 **Q.** And indeed, slightly later in September, it became clear
 19 that at least two of those local authorities had imposed
 20 bans on visits without the incident management team
 21 input or any input at all, actually, from Public Health
 22 Wales. And in those situations, did you write to those
 23 local authorities as well?
 24 **A.** We wrote to all authorities in Wales and we were very
 25 clear. I think where you've got the decision made by
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1 upon -- well discussed with both, you know, the Public
 2 Health Wales colleagues and other partners. We gave
 3 good advice to try to support and enable visiting to
 4 take place in Wales.
 5 **Q.** Thank you. And in terms of the guidance that you wrote
 6 out, certainly you were informed that the Older People's
 7 Commissioner was content with that guidance, and
 8 reported back to you that there had been an increase,
 9 then, in facilitation of those -- at least the outdoors
 10 visits --
 11 **A.** Yes.
 12 **Q.** -- and indeed, in some cases, those more exceptional
 13 visits?
 14 **A.** Yes.
 15 **MS CECIL:** Thank you.
 16 My Lady, is now a convenient moment for a break?
 17 **LADY HALLETT:** Thank you very much indeed. I shall return
 18 at 3.20.
 19 (3.05 pm)
 20 (A short break)
 21 (3.20 pm)
 22 **MS CECIL:** Thank you.
 23 My Lady, if I may now pick up, please, on where we
 24 left off on visiting restrictions. We had reached the
 25 point of the imposition of local restrictions within
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1 the incident management teams, I think we can understand
 2 that restrictions are because of the local prevalence,
 3 so we can understand the decisions being made. What we
 4 would not want is those decisions to be made in
 5 isolation, nor for any length of time that is unduly.
 6 **Q.** And you referred to it briefly earlier, but at that
 7 stage, in addition to the more broad ability to visit
 8 outside or to see people outside in terms of the broader
 9 regulations, under the actual coronavirus regulations,
 10 visits to care home residents were an acceptable reason
 11 to nonetheless visit, weren't they?
 12 **A.** Mm, yes.
 13 **Q.** You could -- it was an exceptional reason to travel.
 14 You could travel under compassionate grounds. That
 15 included visiting end of life, or where those absences
 16 could have a significant impact upon those residents?
 17 **A.** Yes.
 18 **Q.** And notwithstanding that being effectively within the
 19 regulations, we still saw -- or you still saw within
 20 Wales, in some areas, those blanket bans?
 21 **A.** Well, you certainly saw decisions being made that were
 22 contrary to the guidance at that time. Some of that,
 23 I understand -- not justifying, but understand that
 24 individuals were, you know, cautious, anxious, worried.
 25 But it's quite clear that we gave good advice based
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1 Wales and the impact those had on visiting restrictions.
 2 **A.** Yes.
 3 **Q.** So we were looking at, effectively, the period up until
 4 September of 2020. I now want to turn, if I may, to the
 5 firebreak because you say there were significant
 6 concerns, and they became fairly acute in relation to
 7 visiting restrictions when the firebreak was imposed in
 8 Wales. Can you explain why that was and how it became
 9 particularly acute?
 10 **A.** Yes, so, you know, thank you. The firebreak was
 11 described as a circuit breaker to try and interrupt the
 12 spread of Covid. We certainly negotiated that an
 13 exception was to have visits to care homes, but
 14 I acknowledge that that was, whilst permissible, was
 15 during that period more challenging because of the
 16 spread of the virus at that point. But it wasn't,
 17 again, as I mentioned earlier, it wasn't restricted but
 18 was on an assessment between the provider of the care
 19 home and the families themselves.
 20 **Q.** And in practice, what did you see start to emerge? Did
 21 you see the same sorts of issues that had taken place
 22 during the imposition of local restrictions in
 23 September, reemerge during that firebreak period in
 24 November -- October through to November?
 25 **A.** I think it was probably, actually, a quieter break for
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1 those issues because I think there was an understanding
2 across Wales of the need to try to interrupt the spread
3 of the virus, so during those, what I would describe as
4 a three-week period, I think where possible, visits
5 continued but obviously some visits wouldn't have taken
6 place during that period.

7 Q. Thank you.

8 Now, throughout this period various other avenues
9 were explored.

10 A. Yes.

11 Q. You've touched upon some of those earlier in relation to
12 the use of devices, obviously?

13 A. Yes.

14 Q. And we've heard a lot of evidence in relation to the use
15 of technology. Also the use of pods.

16 A. Yes.

17 Q. There was a pilot in relation to pods that was rolled
18 out, and then also pilot LFT testing of visitors as well
19 that was rolled out --

20 A. Yes.

21 Q. -- prior to the Christmas period, and you described that
22 as being particularly important because of the value of
23 Christmas, essentially, to those residents and their
24 loved ones.

25 A. Yes, I mean, it's interesting, I love Christmas, I'm

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1 to provide clarity over the changes in visiting
2 guidance.

3 To be clear, and just to explain, that Coronavirus
4 Control Plan alert level document in terms of Wales'
5 social care services, linked social care testing,
6 infection prevention and control arrangements, and so it
7 was clarity in two respects, firstly over the testing
8 requirements and secondly over the IPC requirements that
9 were to be put in place, including visiting.

10 A. Yes, it was.

11 Q. Now, at this point, visits continued to be allowed in
12 exceptional circumstances. They were not limited to
13 end-of-life care?

14 A. No.

15 Q. But notwithstanding that, there was some initial
16 confusion, and, further, reluctance on the part of some
17 care homes to allow visits at all. And indeed, we've
18 heard some evidence in relation to that.

19 A. Yes.

20 Q. With individuals not being able to see their family
21 members throughout that period.

22 Why? Did you understand why these care homes were
23 reluctant at that point to allow visitors in --

24 A. Yes.

25 Q. -- notwithstanding the guidance?

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1 a Christmas person. Not that my Lady needs to be aware
2 of that, but recognise that the pods especially were
3 a longer-term investment by government and that was
4 really recognising that, you know, the need and the
5 wellbeing needs of individuals to see their loved ones.
6 So, you know, certainly I and my colleagues in the Civil
7 Service worked really, really hard to try and support
8 and, you know, I was really pleased that ministers, you
9 know, financially supported both purchasing pods by us,
10 but also I think it was something like 55 were financed
11 in addition to that, as well.

12 And as you've mentioned using lateral flow tests.

13 Later into the spring period, you know, we'd support
14 volunteers, as well, to support visiting, and really
15 good work across the sector.

16 Q. Now, I want to turn, if I may, to the period surrounding
17 Christmas and going into January, so effectively
18 infections are rising, notwithstanding the firebreak.

19 A. Yes.

20 Q. It's essentially coming towards the peak of the second
21 wave, and alert levels were then put in place,
22 essentially, for social care services, as well, and in
23 relation to those alert levels, the guidance aligned to
24 those alert levels. And that was a first
25 sector-specific plan you describe within the UK seeking

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1 A. Yes. No, thank you.

2 I do understand why they were worried, concerned.
3 I think it was very natural to be worried, concerned.
4 I think the second wave is probably the most painful
5 wave for a lot of us, because the first time we had gone
6 through, we had learned so much and put in so many
7 different features to support. But still, as community
8 transmission rose, so did the prevalence within care
9 homes. And I think that's why it was, at that stage,
10 there was a nervousness.

11 What we continued to do was try to support and
12 enable and maintain that openness to supporting
13 visiting.

14 Q. In terms of the use of exceptional circumstances, or the
15 term which was contained within it, which was
16 "absolutely essential", in terms of permitting visits,
17 do you think that contributed to some of that perceived
18 lack of flexibility for care home --

19 A. I actually thought the plan was really helpful. I think
20 the alert levels were really helpful. And I think as we
21 move into '21 and levels changed within Wales, I think
22 it was also clearer, in terms of being able to, you
23 know, step down the alert levels as well, and open up.
24 So I think, actually, I found it -- I found it a helpful
25 plan, especially as we move into 2021.

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1 Q. In terms of looking to the future, are there any
 2 particular recommendations that you -- or lessons that
 3 you've learnt from that process, including the alert
 4 levels document, the framework, that you think would be
 5 helpful in a future pandemic, and can work on those be
 6 done now?

7 A. Yes, I think definitely. Yes, I would agree.

8 Q. Now, I'm not going to go through the subsequent
 9 iterations, but suffice to say there were a number all
 10 the way through, essentially, all the way through
 11 including Omicron, and then coming out of Omicron and
 12 then the learning to live with Covid strategies or
 13 Covid-zero within Wales. Just in terms of care homes
 14 and their capacity to manage visits, to what extent were
 15 practical constraints a real consideration within Wales,
 16 for example the layout of the home, whether they have
 17 outdoor grounds to accommodate outdoor visits, all of
 18 those sorts of issues?

19 A. Yes, all of those issues were definitely being taken
 20 into account and, you know, because Wales has
 21 a different profile around care home owners, a lot of
 22 owners with one or two homes, you know, we were then
 23 having to accommodate workaround support around
 24 different physical environments. But they were offered
 25 advice, assistance and, as we had mentioned, you know,

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1 this any time soon. Please. I hope so. But if we did,
 2 we've learned that if we can do these things earlier,
 3 then we can enable -- so there's no doubt that that was
 4 a good thing to do and, you know, something that, again,
 5 as I mentioned, as -- as lessons learned, you know, you
 6 can certainly look at what worked well and can you do
 7 that earlier in the cycle.

8 And they were much more protective and supportive,
 9 and, you know, arrangements for cleaning and all the
 10 things that go with that were well in place.

11 Q. And just to deal with the timing of that being
 12 November 2021, were these -- were pods or anything of
 13 that nature, accommodations to assist care homes in
 14 providing visits, considered at a much earlier stage or
 15 was it something that really came about in the autumn to
 16 winter period?

17 A. In truth, it had really come about in -- at that period.
 18 I did think we were being innovative and supportive.

19 Q. Now, if I may, I'm going to turn to the care homes and
 20 action plan.

21 A. Yes.

22 Q. There will be some further questions upon this in due
 23 course, but if I could just deal with it in this way.
 24 It was published on 30 July 2020.

25 A. Yes.

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1 visiting pods and other things that we thought would be
 2 good enablers to creating and maintaining those
 3 relationships between the loved ones.

4 Q. If I can just pick up on visiting pods, which were
 5 obviously a very good innovation for the sector, we've
 6 also heard that some care homes were creating their own
 7 visitor pods --

8 A. Yes.

9 Q. -- earlier, effectively, in the pandemic. Obviously the
 10 pilot was rolled out in November of 2021. Is there some
 11 learning to be done there, and could that have been
 12 effectively put into place much earlier? And the reason
 13 I ask that is not least because of the particular
 14 vulnerabilities of many of those in the care home
 15 sector, in terms of cold and being outside and all of
 16 those sorts of issues.

17 A. Of course I wasn't quite sure I got the date right
 18 there, so -- just to say, because my understanding is
 19 that we did the care home pods in November 2020, leading
 20 up to that --

21 Q. Apologies, I meant November -- (overspeaking) --

22 A. Yes, I wasn't sure I heard -- my hearing sometimes,
 23 I wasn't sure if I heard the date correctly.

24 And I think -- you know, again, all of the learning
 25 will be -- you know, hopefully we don't have to face

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1 Q. The aim of the Care Homes Action Plan was to directly
 2 address the challenges that were being faced by those
 3 care homes during the pandemic. So this is at a point
 4 where, to place it in context for you, the restrictions
 5 were being relaxed coming out of wave 1 into the summer
 6 period.

7 You explain that that was a product of your
 8 directorate and aimed to learn from the first wave to
 9 prepare for a further wave?

10 Now, the Older People's Commissioner for Wales,
 11 Heléna Herklots, had called for an action plan in a
 12 letter dated 14 April 2020.

13 A. Yes.

14 Q. Were you aware of that?

15 A. Yes, I was.

16 Q. And indeed, she had sent you an email also, hadn't she,
 17 following up on that, explaining that she -- and that
 18 she wanted an action plan like that announced in
 19 England? What prompted that Care Homes Action Plan?

20 A. Well, I think at the time, when the Older People's
 21 Commissioner helpfully raised that, the Deputy Minister
 22 was able to consider, we were still very much in
 23 a position where our staffing capacity wasn't really in
 24 a position where we could have said, "Right, we'll do an
 25 action plan today", because actually what we were doing

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was largely working, you know, flat out on the actions that ended up being the actions within the action plan.

So it wasn't that work wasn't being done, because it was being done, but once we hit that summer period, you know, the Deputy Minister was really keen that we develop an action plan -- set that up -- from us, was very clear in June that she wanted it and, you know, she was very much about people's rights and promoting and supporting. So that was at the stage then where the minister was keen for the action plan to be developed.

Q. Indeed. And if I can just draw up on the screen, please, INQ000253707, this is the update provided to ministers on the summary of the progress that's been made against the action plan, so looking at what was achievable and what were the next steps.

And I just want to deal with, if I may, the first one which is the development of a clinical contingency template to provide further advice and support for individual care homes. So that's really dealing with IPC management, how to manage individuals with infections within the home, as it says here, it will include environmental staff management, minimising staff movement, personal protective equipment, PPE, testing, considering their own resident group, staff group, environmental layout and service delivery.

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So we're talking about a fairly significant period in getting that --

A. Yes.

Q. -- checklist together. Now, you've explained the work that was being undertaken?

A. Yes.

Q. But would you agree it would have been obviously a very useful tool, you've described it as a toolkit, for those care home providers and individuals concerned with the provision of care to have had earlier?

A. Absolutely. But important to bear in mind that, you know, environmental health officers were going into homes who had infection control issues twice a week. There were a whole range of other measures alongside that. But I do believe it was a very important step forward and hence why I personally endorsed -- I'll call it the workbook. I know it's got a proper title, but I've endorsed that and it's really taken -- you know, it's taken steps further forward from 2020.

Q. Indeed. And your directorate would not have produced it had it not been considered to be an important, valuable tool for that sector to use?

A. No, and indeed --

Q. That's why I ask --

A. -- working with Public Health Wales and partners who

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You may already have touched upon the lack of capacity in your team and that may be the reason, but why was this only taking place now, effectively, with a target date of October 2020?

A. Well, I think, I think IPC advice was being given to care homes much earlier than that date. But what this was about was developing what I'll term as a toolkit that could be used with further training and support. That toolkit was produced. Subsequently, a lot of work across Social Care Wales, Public Health Wales, and that work has been progressive to this day. We now have a, you know, a work book and training materials that I've endorsed alongside the Chief Nursing Officer, but it would be fair to say that work was taking place, you know, before this but it was about the toolkit which we did produce.

Q. Thank you. Just dealing with that toolkit that was produced, it became a checklist; is that right?

A. Yes.

Q. And there was a further update following on from this update in October, in December, and at that point that had still not actually been completed albeit that an initial checklist had been developed but not rolled out and it was later confirmed that the checklist was then sent in January to be circulated onwards.

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have been instrumental in this.

Q. If I can also deal with the rapid review that was taking place alongside the development of the action plan, that was a review by Professor John Bolton, an independent review to look at the experiences of care homes during the pandemic.

Now, there were concerns raised by Heléna Herklots, the Older People's Commissioner, that the review would not sufficiently engage with what had gone wrong and instead would overly focus on what had gone right in the pandemic.

What do you say about that?

A. Well, you know, to be fair, it's really important that the Older People's Commissioner raises concerns and issues. That is good for us because we are able to consider and respond. You will have a copy of, you know, the material that was sent out at the time. That clearly talks about weaknesses, gaps. And, you know, I think, you know, Professor Bolton did a really good job at, you know, speaking directly to regions, gathering what worked well but gathering what needed to be improved, and come up with a very clear set of recommendations and advice, which I found very useful, and also the team found very helpful, because we were able to incorporate that into the care action plan work

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1 as well.
2 **Q.** Thank you. That deals with my next question, which was
3 how was it used.

4 If I may, then, turn to one aspect that was
5 identified within the action plan, and that's the one of
6 staff movement and the risk of transmission.

7 So staff movement, we've heard, is a significant
8 challenge.

9 **A.** Yes.

10 **Q.** It's an ingress route for infection across the care
11 sector in that respect. Now, it's been a longstanding
12 understanding within the adult social care sector in
13 relation to other infectious diseases, hasn't it?

14 **A.** Yes.

15 **Q.** So this understandably was a significant concern for
16 those in receipt of care, and we've touched upon those
17 in receipt of domiciliary care, and the concerns and
18 anxiety that they expressed at the time.

19 If I could ask, please, for the witness statement of
20 Catherine Griffiths to be pulled up on the screen.
21 Page 9, please, paragraph 30. Thank you.

22 Here, it sets out that:

23 "A significant concern of [Covid Bereaved Families
24 for Justice] Cymru was the risk of staff spreading the
25 virus between homes. The use of agency staff was
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1 that it's one of the ingress routes, and here it's
2 a reference to your evidence, your witness statement,
3 where you accept that despite the risk posed, as you
4 said, the pressure on the system put the social care
5 sector into a position in which they could not prevent
6 it, and so that was particularly frustrating to their
7 members, who found that many care homes were also still
8 accepting patient discharges from hospital at the same
9 time.

10 So these were concerns of those residents and their
11 loved ones in relation to restriction, but essentially
12 there was just simply not enough capacity within the
13 workforce to enable the policy to limit staff to one
14 home only.

15 **A.** Certainly at the early stages of the pandemic, you know,
16 from the feedback that I had from the sector, was that
17 was not possible. However, I did write out in August,
18 I think it's August 17, really clearly setting out the
19 expectation around, you know, allocation of agency
20 worker to single homes. I felt that was doable then
21 because the rates, if I remember correctly at that
22 stage, of allocation to individual homes was something
23 like 90% of agency workers in Wales, so that was really
24 pushing home that message about risk and how to manage
25 risk.
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1 commonplace."

2 Firstly, if I can stop there, that's correct also,
3 isn't it, of the situation in Wales, the use of agency
4 staff?

5 **A.** Yes, yes.

6 **Q.** "This inevitably led many staff to move between homes or
7 even region to region."

8 And just again pausing there, there was a point,
9 wasn't there, where individuals were moving from region
10 to region because of workforce shortages within Wales?

11 **A.** There was certainly, you know, at a critical point in
12 the pandemic, where we were actively encouraging, you
13 know, allocation of workers to single homes only, but
14 there was no doubt, and it's something that is about
15 workforce planning for the future, for the now, we
16 clearly -- there were times where the sector could not
17 prohibit the use of workers across, because of the
18 pressures that they were under. And that is a very sad
19 thing to say, but I know a lot of work was done to try
20 and keep it to the absolute minimum.

21 **Q.** Indeed, and if we continue on, we see that the concern
22 is that the continuous source of movement likely
23 contributed to the spread of virus between homes, and
24 we've seen that that's certainly is the findings of the
25 Vivaldi Study, and we've heard from Professor Shallcross
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1 **Q.** Certainly at the outset you explained that had you
2 instituted such a policy barring the transfer, the
3 working between different homes, then you would not have
4 been able to implement the hospital discharge policy,
5 for example, at all, or other policies, including and
6 down to just delivering basic levels of care?

7 **A.** It would have had impact across those systems, as you
8 say, the whole-system thinking, of course, but
9 importantly, it would have had impact on the quality of
10 care within those care homes themselves.

11 And that was the advice that was coming from, you
12 know, care providers to me at that stage.

13 **Q.** And looking to any future pandemic, specifically, is
14 there anything that you consider that could be done to
15 resolve that position?

16 **A.** Well, I think, I think -- yes, I do. I think the whole
17 workforce planning and the whole workforce investment is
18 absolutely critical. There are challenges that the
19 sector faces that I think we can address, but perhaps
20 I'll come on to some of those, I'm sure, during the
21 discussion. Thank you.

22 **Q.** Of course. And related to that, were issues in relation
23 to staff absences.

24 **A.** Yes.

25 **Q.** And again, if I can call up the same witness statement
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1 but paragraph 33. It picks up on your earlier comments
 2 about the sector being fragile but it explains that the
 3 absences resulted in a dramatic drop in the quality of
 4 care afforded to their loved ones. Certainly we've seen
 5 some evidence of that from ADASS and organisations, with
 6 limitations to what they could achieve.

7 And then it continues to go on through that:
 8 "... Denbighshire saw 15% of its local authority
 9 social services workforce take time away from work due
 10 to COVID-19 ... staff absence varied between 10 to 35%
 11 through the relevant period ..."

12 And that's when it really resulted in the need for
 13 staffing, mutual aid or the introduction of agency
 14 staff.

15 So again, increasing the infection rates.

16 A. Yes.

17 Q. And you've dealt with the issues of workforce capacity.
 18 Just picking up on the ability to self-isolate, we've
 19 heard about financial concerns of individuals within the
 20 sector. Is that something you've given thought to?

21 A. Yes. That was. There was concern, and I know we were
 22 able to support, through the enhancement to statutory
 23 sick pay, and I know that we were able to support with
 24 particular payments, recognition, rewards to workforce
 25 who were, during the pandemic, working above and beyond
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1 with the lack of adequate PPE at the time?

2 A. No, certainly my understanding was -- throughout that
 3 period was based upon the -- the scientific advice
 4 rather than the amount of PPE.

5 In fact, I think the efforts around supplying PPE,
 6 you know, were gone to at great lengths.

7 Q. Now, the Inquiry has heard significant and received
 8 significant evidence of PPE shortages in care homes
 9 beyond March 2020 --

10 A. Yes.

11 Q. -- beyond the initial period but for quite some time.

12 So, for example, in April 2020 Care Forum Wales sent
 13 a letter to Mark Drakeford saying barely receiving any
 14 sufficient PPE. Chris Llewelyn of the Welsh Local
 15 Government Association similarly refers to shortages,
 16 care home managers provide evidence that they were
 17 locking PPE away, stockpiling it, and we've heard some
 18 evidence that social care workers were reduced to using
 19 one mask per shift as a consequence. Equally, care
 20 homes becoming reliant on people in the community making
 21 masks and gowns. And we've heard some further evidence
 22 this morning about difficulties in relation to what the
 23 NHS central supply chain was able to provide at that
 24 time when the government took it over?

25 Do you accept that there remained widespread PPE
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1 any expectations at that -- what they were doing was
 2 absolutely fantastic.

3 Q. Thank you. If I can turn, then, to the issues of
 4 infection prevention and control and PPE.

5 A. Yes.

6 Q. The initial advice was that PPE was only required when
 7 dealing with those Covid-positive cases. In hindsight,
 8 do you think that was the correct advice?

9 A. I think I accept that as the advice that was at the
 10 time -- accept that as the advice.

11 Q. I just want to, again, touch upon, if I may, that
 12 certainly the possibility of asymptomatic transmission
 13 was discussed within the initial Health and Social
 14 Services Group Covid-19 Planning and Response Group as
 15 early as 20 February. Given that, and the potential for
 16 asymptomatic transmission, why were social care
 17 providers not advised to wear PPE when caring for all
 18 residents discharged from hospitals, as a precautionary
 19 measure?

20 A. No, it's a very fair question. My response is that the
 21 continuing advice to us, in terms of, you know, the
 22 medical advice, the scientific advice, as you will have
 23 seen from my statement, continues to recognise the risk
 24 differently between symptomatic and asymptomatic.

25 Q. Was that based on scientific advice or was it more to do
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1 shortages in care homes after the Welsh Government
 2 assumed responsibility on 19 March 2020?

3 A. I think it's a challenging question, do I accept? And
 4 thank you for the question, by the way.

5 I think what I would say in response to that is, you
 6 know, the duty to provide PPE, the government stepped
 7 into that space, so we stepped into a space that was
 8 occupied by local government and providers themselves.
 9 I think that was the right thing to do and I think that
 10 was important.

11 There was always enough PPE in the system.

12 I had the very helpful military, asked for them to
 13 do an assessment. They did the assessment between
 14 something like 8 April to the 18th, provided a report on
 15 the 21st. Logistics to making sure. And I think there
 16 were lots of -- this was the first time in that chain,
 17 almost like a supply chain, if I can put it in that
 18 jargon term, which no one had done before, so people
 19 were sometimes stockpiling, and it took time but PPE was
 20 getting out.

21 So I don't think there was a shortage, actually,
 22 overall, of PPE. We run very close, however. And I was
 23 personally involved in conversations with, you know, the
 24 Shared Services from the NHS, and we come very close on
 25 occasions, but the -- with a matter of days in
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1 provision, but we never did run out, and we always
2 got -- and when, you know, directors of social services
3 phoned me up late in the night saying, "I'm worried,
4 I need PPE", I was able to phone the Shared Services and
5 they responded.

6 We got into different regulated beat with the
7 sector, which did begin to ease those worries, but
8 you're absolutely right, there were lots of challenges,
9 but there was PPE, although recognising how close
10 sometimes we come to the wire.

11 **Q.** And presumably that PPE, where you say it was
12 sufficient, that was based on whatever guidance was in
13 place at the time?

14 **A.** Yes, of course.

15 **Q.** So whatever the guidance said, you're saying that was
16 sufficient to accommodate that?

17 **A.** And we scaled up, and I think -- I think actually one of
18 the learning points -- forgive me for coming back in,
19 but one of the learning points is how that national
20 approach really benefited around PPE.

21 **Q.** Thank you. I've just got one last question on this
22 topic before moving on, if I may, and that is, in terms
23 of care homes and their ability, firstly, to isolate,
24 and, secondly, their ability to provide good
25 ventilation, just very shortly, what is your

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1 If I can just call up, please, INQ000500163, go to
2 pages 2 to 3. And this is being escalated to you,
3 essentially, from Care Inspectorate Wales.

4 If I can go over the page, please, to page 3. These
5 are concerns about a recent death at a care home, and
6 they explain that paramedics were called out but,
7 because that notice was in place, they were not admitted
8 to hospital.

9 No palliative care package -- and I'll move to that
10 in a moment, was put in place -- controlled drugs were
11 not issued, and they passed away within 24 hours, and it
12 deals with the nature of that. And obviously a far less
13 dignified death than one would have hoped for or would
14 have been typically the case within an adult social care
15 setting.

16 And in regard to that, it explains that they're
17 residential services, they're being asked to operate
18 outside of their registration by becoming nursing homes,
19 and these were homes without those nursing capabilities
20 operating like a mini hospital ward.

21 "We all know that we have to do our bit to help the
22 NHS save lives but they are asking too much in this
23 instance."

24 If we go back, please, to page 2 -- and page 1 of
25 it, sorry, apologies.

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1 understanding of the provision within Wales?

2 **A.** Yeah, it's mixed provision. I've been in many care
3 homes in Wales myself personally, and I know that
4 providers are always working to, you know, have good
5 ventilation, good standards. The Regulation and
6 Inspection of Social Care Act also has set higher
7 standards than previous legislation as well.

8 **Q.** Thank you. I now want to move to the final topic, if
9 I may, that I have questions for you in relation to, and
10 that is on DNACPRs, so do not attempt cardiopulmonary
11 resuscitation notices, please.

12 I understand that you and your team had limited
13 involvement in the policy and guidance, but I just
14 wanted to pick up on where your team did intersect for
15 those issues.

16 Now, Gillian Baranski, the chief inspector of Care
17 Inspectorate Wales, has provided evidence with regard to
18 the inappropriate use of those notices, certainly in one
19 respect being used as a proxy for do not treat.

20 And so, again, we've also heard evidence from
21 Mrs Hough, she described the challenges she faced in
22 terms of taking residents to hospital because they had
23 those in place and that care home providers believed
24 that those notices were resulting in automatic
25 non-admittance to the hospital.

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1 What we see here is it's being described as there
2 being a race by GPs to put in place notices. Now, there
3 are concerns about blanket DNACPRs and also that such
4 notices were being put in place without any discussion
5 with residents or their families. No engagement, in
6 short. What did you do in response to those concerns?
7 They're coming to you in your office.

8 **A.** Yes, so although I didn't have, we didn't -- I don't
9 have a remit, I wasn't responsible for the policy, you
10 know, I was, like anyone would have been, deeply
11 affected by the stories, the impact coming to me.
12 Certainly, I raised it within the executive team that
13 I'm a part of. I had discussions with colleagues who
14 held responsibilities. And I think it was accepted by
15 everyone that one case was one case too many, actually,
16 I think. And although, you know, looking back I think
17 they were a small number of examples, they were examples
18 that we would not have wanted to see in Wales.

19 And so the Chief Nursing Officer, the Chief Medical
20 Officer, you know, wrote out to the system clearly
21 explaining, and I think that was, again, around
22 17 April.

23 **Q.** Thank you. And one aspect of this was also the use of
24 the clinical frailty score. Now, Module 3 has heard
25 evidence on that, and you provide various observations

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1 in your statement, but just to deal with that in
2 conjunction with these notices, Covid Bereaved Families
3 for Justice expressed the view that many members felt
4 that they were being disproportionately affected, they
5 were being neglected on the basis of age, they were
6 being viewed as too old, and there were similar concerns
7 expressed by disabled people some of whom also had
8 notices being put in place including in circumstances
9 where they plainly ought not to have been.

10 Was there a lack of care and respect for older
11 people or those more vulnerable to Covid?

12 **A.** I think the answer back to that one is that there was
13 a few examples which we would not have wanted to see in
14 Wales, but the approach certainly of the Welsh
15 Government, both at a minister level and an official
16 level, was one of wanting to support older people,
17 support people with disabilities across the board, and
18 a number of actions that we tried to take were in the
19 supportive arena.

20 **Q.** Thank you. And again, we saw from that email, and
21 indeed from other evidence that the Inquiry has
22 received, that there were care homes without nursing;
23 they did not have sufficient end-of-life care; they had
24 a lack of medication stocked, oxygen being a particular
25 issue. To what extent can anything be done about that

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1 within that, that individual should be caught within
2 those policies.

3 **Q.** I've just been asked if I may very briefly, Mr Heaney,
4 to clarify one matter that goes back, actually, to
5 questions I was asking at the beginning, and that's in
6 respect of the decision to test all patients on
7 discharge on 15 April. You said that at that point both
8 yourself and the CMO, Sir Atherton, wanted a change in
9 policy.

10 Can you please clarify, who actually made that
11 decision -- (overspeaking) --

12 **A.** Good question. Thank you for asking.

13 So on the 14th there was a, you know, clear, I think
14 it was a Technical Advisory Cell advice, and often
15 coming from SAGE, very clearly identifying the risks.
16 England, as I mentioned earlier, changed the policy.
17 There was a ministerial meeting held on relation to
18 social care on the 15th.

19 **Q.** There was.

20 **A.** Yes, and in that meeting we discussed the testing and
21 discharge from -- discharge, that's where Frank
22 Atherton, Sir Frank Atherton, the Chief Medical Officer
23 of Wales, was tasked with going away in terms of looking
24 at that policy, and then there was a cabinet meeting
25 held that discussed it further on 22 April, and I

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1 to help, in terms of a future pandemic?

2 **A.** Yeah, I think it should happen, you know, it does happen
3 day in, day out, and it must happen day in, day out. It
4 must happen today. So anyone who has, you know,
5 a palliative care, an end-of-life pathway, deserves
6 dignity, respect, support, and there's a whole range of
7 measures, so although I'm not the policy lead, I am
8 familiar with the policy and I can see within that that,
9 you know, if we adhere to that policy and that
10 framework, then that is about working together with
11 people and their loved ones around these decisions.

12 **Q.** Thank you.

13 And then my final question, please, in relation to
14 the use of these notices. The CQC undertook a review,
15 obviously that was in England, and subsequent to that,
16 several reviews have taken place of these practices in
17 Wales. But each of these recent reviews concentrate on
18 health boards and NHS trusts. There's been no review in
19 relation to the situation within social care. Do you
20 consider that that's something that is necessary?

21 **A.** I think the consideration of those in terms of --
22 because these are clinical decisions, these are medical
23 decisions. So I think starting from that basis is the
24 right basis. But then, of course, you should always
25 consider what the setting is for the individual, but

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1 believe it was in those settings where that decision to
2 move forward on the discharge testing was agreed.

3 **MS CECIL:** Thank you very much.

4 My Lady, those are my questions.

5 **LADY HALLETT:** Thank you very much, Ms Cecil.

6 Mr Stanton, should be straight across the hearing
7 room, Mr Heaney.

8 **THE WITNESS:** Thank you.

9 **Questions from MR STANTON**

10 **MR STANTON:** Thank you, my Lady.

11 My Lady, Mr Heaney has already covered very fully
12 two of the three permitted questions so I just have one
13 question.

14 **LADY HALLETT:** Thank you.

15 **MR STANTON:** Good afternoon, Mr Heaney.

16 **A.** Good afternoon.

17 **Q.** I ask questions on behalf of the Covid-19 Bereaved
18 Families for Justice Cymru. The single question I have
19 for you relates to asymptomatic testing in care homes,
20 which you've already touched on some aspects of in your
21 answers.

22 Can I refer you, please, to an email from Margaret
23 Rooney, the Deputy Chief Inspector of Care Inspectorate
24 Wales, on 24 April 2020, which is at INQ000198311.

25 This email sets out Ms Rooney's views about the need
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1 for asymptomatic testing at that date, and states:
 2 "In terms of the global testing: having read the
 3 document entitled 'Covid-19 in care home settings:
 4 Enhanced Prevention and Outbreak Management' and heard
 5 feedback from the other inspectorates (in particular
 6 Scotland) about staff with no symptoms testing positive,
 7 I think all staff (and residents in care homes) should
 8 be tested whether they are symptomatic or not and in
 9 truth, these tests need to be repeated at regular
 10 intervals.

11 "Appreciate the capacity to do this needs to be
 12 there, but I think the situation seems to have escalated
 13 to the point where this sort of intervention may be
 14 warranted."

15 Mr Heaney, I think I'm right in saying that very
 16 shortly after this email, that statement was broadly in
 17 line with your own personal position; is that right?

18 **A.** Yes, I think I actually might be earlier in this email
 19 chain but I could stand corrected, you know, certainly
 20 I was asking very similar questions to my colleague in
 21 Care Inspectorate Wales.

22 **Q.** However, the First Minister, Mr Drakeford, took
 23 a different view and repeatedly stated on 29 April, and
 24 6 May in the Senedd, that there was no clinical value in
 25 asymptomatic testing.

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1 upon the medical advice and the scientific advice at
 2 that time.

3 **MR STANTON:** Thank you.

4 Thank you, my Lady.

5 **LADY HALLETT:** Thank you, Mr Stanton.

6 Ms Morris, who should be just slightly to your right
 7 there. There you are.

8 **Questions from MS MORRIS KC**

9 **MS MORRIS:** Good afternoon, Mr Heaney.

10 **A.** Good afternoon.

11 **Q.** I ask questions on behalf of the Covid Bereaved Families
 12 for Justice UK. I have three short topics for you,
 13 please. The first is touching, again, on the Care Homes
 14 Action Plan.

15 **A.** Yes.

16 **Q.** Ms Cecil King's Counsel ascertained with you this
 17 afternoon that Ms Herklots had called for a care home
 18 action plan in April and by the time it came out in
 19 July 2020, it was coming out as restrictions were being
 20 lifted. So why had it taken until July 2020 for one to
 21 be issued?

22 **A.** So the Deputy Minister for Social Services agreed in
 23 June 2020 to develop a care home action plan.
 24 Before that date we were active in the actions and
 25 busy in the actions, but we just really didn't have

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1 And my question for you is: are you aware of any
 2 scientific or ministerial advice at this point in time
 3 that stated that routine testing in care homes had no
 4 clinical value?

5 **A.** I am aware of advice going up to the minister. I'm
 6 certainly aware of advice that went up in detail, on 30,
 7 I think, of April, that went into a wide range of
 8 considerations and was quite open, actually, in some of
 9 the changes in the science, but where we were. So the
 10 comments that First Minister then was making and the
 11 minister were making, were based upon the advice that
 12 was still coming to them. As I mentioned earlier, the
 13 critical determination around the change in decision
 14 then happens on 12, 13 May, with some real clarity
 15 coming forward. But then just supported the earlier
 16 thinking that was around in some parts. If that makes
 17 sense. I hope it does.

18 **Q.** It does. It's helpful. Thank you.

19 Can I just clarify, Mr Heaney, you're not saying
 20 that the ministerial advice of 30 April indicated that
 21 asymptomatic testing had no clinical value, because that
 22 was an advice that contained studies such as the Public
 23 Health England Easter 6 study.

24 **A.** Yeah. No, and it wasn't, you know, I know we wrote the
 25 advice, but that advice was very thoughtful and based

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1 capacity at that particular stage to go into a Care
 2 Homes Action Plan. As soon as the minister felt that
 3 was the right thing and the timing was right, we did
 4 that, but that is not to say that actions that
 5 ultimately you will see taking place, weren't taking
 6 place, because they were.

7 **Q.** So Heléna Herklots, the then Older People's
 8 Commissioner, for Wales --

9 **A.** Yes, of course.

10 **Q.** -- told the Inquiry yesterday that she was told
 11 initially by the Welsh Government that the plan would
 12 add "no value". And she said yesterday that she found
 13 this disappointing and didn't address the urgency of the
 14 issue.

15 So why did the Welsh Government feel that that plan
 16 wouldn't add value?

17 **A.** So I think it's -- I would ask us perhaps on this one to
 18 go back to the original letter that the Deputy Minister
 19 sends to the Older People's Commissioner, because I do
 20 not believe that is what is said within that letter.
 21 I don't believe the wording of that letter from the
 22 Deputy Minister says "no value". I believe, at that
 23 time, what the Deputy Minister was saying was: at this
 24 time, will it add value?

25 And it's about discussion.

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1 And she didn't write out saying that we wouldn't --
 2 she wouldn't be doing it in the future, but at that --
 3 so I would probably suggest we need to just go back and
 4 check the wording of that letter, because I'm not sure
 5 that that is a representation of what actually the
 6 Deputy Minister and the government was saying.

7 **Q.** I'm not going to take us back to that because the
 8 Inquiry had it in front of Ms Herklots yesterday and has
 9 had that evidence, but your position is that you don't
 10 know whether that was in fact what was being said in the
 11 letter; is that right?

12 **A.** I don't believe it -- I'm being clear, I don't believe
 13 that -- I do not believe that's what's said in the way
 14 that it's worded within the letter. No, I don't.

15 **Q.** Thank you.
 16 Second topic: visiting guidance. So between
 17 June 2020 and March 2022, you've said that there was
 18 14 versions --

19 **A.** Yes, there was.

20 **Q.** -- so 13 revisions --

21 **A.** There was.

22 **Q.** -- before transitioning to a longer-term plan.

23 Do you agree that this amount of revisions would
 24 have been confusing for the majority of people, and in
 25 particular for those who were trying to put it into

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1 **Q.** -- the Welsh Government's focus was on protecting the
 2 NHS, which had then had a disproportionate affect on the
 3 adult social care sector.

4 Now, in March 2020, you attended a Covid core group
 5 with the First Minister, where the NHS were projected to
 6 reach maximum capacity within four or five weeks, which
 7 you said reinforced the need to take urgent preventative
 8 measures to prevent the NHS from becoming overwhelmed.

9 Does that approach confirm that you were in fact
 10 prioritising protecting the NHS?

11 **A.** I think it's a really good, searching question, so thank
 12 you. And pausing and reflecting on it, my thoughts then
 13 were, although we used the title "protect the NHS", for
 14 me it was "protect the NHS, protect social care". So
 15 that was the ethos that I was always working in. And
 16 I do believe -- I really do believe this -- that we were
 17 faced with some really difficult choices.

18 But the capacity within the NHS, you know, having
 19 seen the reasonable worst-case scenario, having seen the
 20 images from Italy in the hospitals and having understood
 21 the kind of conversations that I was involved in, it was
 22 actually -- you know, I do believe that we were -- you
 23 know, Welsh Government was trying to support the NHS to
 24 be able to deliver to save people's lives. So I don't
 25 think -- I don't see it as a straightforward choice of

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1 operation?

2 **A.** I agree that that was a challenge, absolutely. And
 3 I think for many families, I know that families
 4 communicated with me directly, and I tried to help and
 5 explain where we were. So absolutely understand that
 6 impact. And, you know, really feel for those families,
 7 as well.

8 What we tried to do to learn, as we did, was that
 9 early in the pandemic we were issuing it very quickly,
 10 so we tried to use, you know, the First Minister's press
 11 conferences to lead and to communicate, so we took
 12 a little bit of time to explain the changes.

13 And as counsel asked me earlier, I think when we
 14 went to the alert stage, I think that ultimately become
 15 more helpful for families in knowing what could happen.
 16 Thank you.

17 **Q.** Thank you.

18 Third and final topic, please, protecting the NHS.
 19 Ms Cecil gave an example of an Every Story Matters
 20 contributor, who said that, in their view, they felt
 21 that the Welsh Government put the needs of protecting
 22 the NHS from collapse ahead of those in care homes, and
 23 in fact it was the view of Melanie Minty, the senior
 24 policy adviser at the Care Forum Wales, is that --

25 **A.** Of course.

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1 protect the NHS, not protect others. And I really
 2 genuinely believe that that was one of the most
 3 difficult times and difficult, you know, decisions that
 4 anyone had to take.

5 But as you said quite rightly in your question, we
 6 had a number of weeks where we knew we would be at full
 7 capacity, and having seen the reasonable worst-case
 8 scenario figures, that was very frightening indeed.

9 **MS MORRIS:** Those are my questions.

10 Thank you, my Lady.

11 **A.** Thank you.

12 **LADY HALLETT:** Thank you very much, Ms Morris.

13 Now it's Ms Jones, who is probably further to the
 14 right of -- or your left.

15 **THE WITNESS:** Thank you.

Questions from MS JONES

17 **MS JONES:** Thank you, my Lady.

18 Mr Heaney, I ask questions on behalf of John's
 19 Campaign, Care Rights UK and The Patients Association.

20 I want to ask you first about problems with data
 21 collection and understanding of the care sector, and
 22 you've referred in your witness statement to the
 23 challenges that are faced by the adult social care
 24 sector and steps that are being taken by the Welsh
 25 Government to improve the collection of social care data

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1 to provide a clearer picture of service delivery and to
 2 support your ongoing work.
 3 I want to know what challenges did a lack of
 4 reliable data about adult social care present during the
 5 pandemic, and what are the concrete steps that the Welsh
 6 Government's been taking to try to address that
 7 weakness.

8 **A.** Yes, thank you for the question.

9 So, you know, I think, you know, the challenges were
 10 around, you know, workforce capacity in care homes,
 11 a whole range of issues from that set of data was -- was
 12 difficult. We introduced the care home capacity
 13 tracker, if I can call it that, to get an understanding
 14 of capacity. That helped during the pandemic.

15 I had discussions with directors of social services
 16 early on and, in fairness, I asked for more data at that
 17 point, which I think benefited us during the course of
 18 the pandemic.

19 I know at that stage some of my director colleagues
 20 were uncertain about that, but they did -- they did
 21 support the direction of travel.

22 We've worked with Social Care Wales to improve data
 23 and we're continuing to work with them. And we've
 24 recently developed the National Office for Care and
 25 Support, which has a data focus. So very much learning
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1 centralised database of data about the care sector, and
 2 a system should be established to ensure that data about
 3 the sector is complete and accurate and available to
 4 decision makers?

5 **A.** Yes, I do. And that's why we have developed the
 6 National Office for Care and Support in Wales.

7 **Q.** Thank you. I'm going to move on to a different topic
 8 now, which is a specific question about the visiting
 9 guidance.

10 You've stated in your statement that version 3 of
 11 the visiting guidance, which was introduced in
 12 August 2020, included an integrated impact assessment
 13 which considered how providers could safely facilitate
 14 visits while addressing growing concerns about the
 15 emotional, mental and physical health impacts of
 16 prolonged separation from loved ones.

17 You say that this impact assessment and then the
 18 version 3 of the guidance took into account the
 19 experience of people living with dementia, based on
 20 evidence provided by the Alzheimer's Society. And
 21 I just wonder if you can help us with exactly how the
 22 Alzheimer's Society's position was reflected in the
 23 guidance and the impact assessment associated with it.

24 **A.** Yeah, I think I would have to take -- the detail, I'd
 25 have to take that away and really reflect upon that.
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1 from where we were to improve the data and data
 2 understanding.

3 **Q.** And are there any specific examples you can give us of
 4 problems that you faced due to a lack of data, or
 5 improvements that would have been possible if you'd had
 6 better data during the pandemic?

7 **A.** Yeah, I mean definitely, and a very helpful question.
 8 I think for me, it's about, you know, I would have liked
 9 to have better data around, you know, the workforce
 10 within care homes. We're very fragmented, different
 11 owners. I would like to have a national picture of what
 12 that looks like. You know, sickness absence and real
 13 live time data.

14 So I appreciate the challenges, but where we would
 15 like to be in the future is probably in a different
 16 place to where we were at the beginning of the pandemic.
 17 And we're starting to make some of those tracks now
 18 through, as I mentioned, the National Office.

19 **Q.** How do you envisage decisions made about the sector
 20 might have been different if you'd had that --

21 **A.** Yes, of course. Of course. They could be. I can't say
 22 they would be for certain but I would like to have had
 23 that data, because it may have -- it would enable us to
 24 have a richer base on which to make decisions upon.

25 **Q.** And do you agree that there ought to be a national
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1 What I can say more generally, you know, I think, is
 2 that, you know, some of the reports produced, I read
 3 them personally, they were very powerful, very helpful,
 4 really raising the voice.

5 What I tried to do, what my team tried to do, was
 6 also ensure that voices were widely heard.

7 We'd commissioned partners to actually being able to
 8 raise the voices of individual groups, older people,
 9 younger adults as well. Some of those we commissioned
 10 through Age Cymru, you know, voices from care in Wales,
 11 All Wales People First. So we used resources like that
 12 to really make sure we could, you know, have a richness
 13 of understanding lived experience.

14 **Q.** Thank you, Mr Heaney, and that might be part of your
 15 answer to my next question as well, which is about the
 16 Care Homes Action Plan.

17 You stated at paragraph 165 of your witness
 18 statement that you wanted the Care Homes Action Plan to
 19 align with the concerns and recommendations that were
 20 made in the Older People's Commissioner for Wales report
 21 on Care Home Voices. I wanted to ask how you ensured
 22 that action plan reflected those concerns and
 23 recommendations, and whether you took any steps to
 24 obtain the views of people who rely on care in
 25 formulating the action plan?
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1 **A.** Yes, thank you for the question.

2 One of the longstanding traits of the policy area
3 that I work in is co-production, working together with
4 people heavily involved in legislation and policy over
5 many years.

6 And certainly at the outset of the pandemic, that --
7 those traditional routes were really troublesome to us,
8 difficult, because of the restrictions. And what we did
9 do, we did commission partners to -- particularly during
10 those pieces of work that you've mentioned -- to do that
11 work for us, and to feed that through.

12 Separately to that, I also had regular engagement
13 points. I chaired a weekly meeting with lots of
14 partners from the sector and they were constantly
15 raising up the voice of their particular, you know,
16 populations that they represented, and that was really
17 important and really powerful.

18 **MS JONES:** Thank you, Mr Heaney, those are my questions.

19 **THE WITNESS:** Thank you.

20 **MS JONES:** Thank you, my Lady.

21 **LADY HALLETT:** Thank you, Ms Jones.

22 And lastly, Ms Beattie. Further behind Ms Jones.

23 **Questions from MS BEATTIE**

24 **MS BEATTIE:** Thank you, Mr Heaney. I ask questions on
25 behalf of Disabled People's Organisations. And I'm also
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1 stage. But I do agree that we would have always, you
2 know, and I think that's what we would support it
3 throughout, our care home visiting -- you know, was
4 where it was enabled to support, especially people, you
5 know, disability, you know, to support.

6 So I think that, you know, from your point is
7 a really good one. I don't think we were intending to,
8 you know, prevent people from being able to communicate,
9 and, you know, obviously I recognise it was a very
10 difficult time.

11 **Q.** The letter, I think probably understandably, referred to
12 the importance of emotional wellbeing and trying to
13 facilitate that.

14 **A.** Yeah.

15 **Q.** But I mean, would you agree that what perhaps was needed
16 was some more formal or structured guidance to care home
17 providers in order to be able to make a decision for an
18 individual about visits that were really essential in
19 order that their needs were met, and so that reasonable
20 adjustments could be made and those needs met and rights
21 protected?

22 **A.** Of course, and I know that partners we worked with were
23 offering advice and support, and as I mentioned in
24 a previous question, some of these were the issues that
25 very helpfully were raised with us at the Planning and
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1 asking about the guidance on visits to care homes.

2 So if I can take you back to your letter of
3 23 March 2020, which you've already been asked about,
4 where you said that visits should only occur when
5 absolutely essential, and as I understand it, that
6 letter went to call care homes, directors of social
7 services, and health boards, is that right?

8 **A.** Yes.

9 **Q.** And you said in the letter that there should not be what
10 you call "routine visiting as previously experienced at
11 care homes". Now, do you agree that that guidance did
12 not expressly accommodate the needs of disabled people
13 who were reliant on visitors, including for daily
14 communication needs? And just to give a concrete
15 example of that, for example, an individual with
16 a cognitive impairment who does not communicate or does
17 not communicate primarily via speech, perhaps, and for
18 whom, therefore, a visitor may be a key interpreter of
19 non-verbal signals and provide key insight into whether
20 they're experiencing pain or discomfort and other health
21 and welfare needs?

22 **A.** And I think that guidance at that stage was at the same
23 time that we went into lockdown. So you're absolutely
24 right to raise that as a concern. That was done with
25 the intention of trying to protect at that particular
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1 Response Group by some key stakeholders, as well.
2 I recall, you know, a number of illustrations that
3 allowed us to really understand the impact of some of
4 the policy decisions, as well, that we were taking, and
5 as we revised policy, we were able to take into a wider
6 consideration of some of the impacts.

7 **Q.** So looking forward, and for any future pandemic, or any
8 visiting guidance of any sort, would you agree that that
9 kind of structured guidance is what is needed?

10 **A.** Yes, I agree. I do agree. I really do.

11 **Q.** And in your evidence earlier I think you said that later
12 on there'd been some really good work across the sector
13 on visiting.

14 **A.** Yes.

15 **Q.** But is it right that the All Wales Forum survey about
16 people with learning disabilities found that even by as
17 late as August 2021, there remained very significant
18 restrictions on visits experienced by people with
19 learning disabilities living in care homes and supported
20 living, with 23% of respondents to that survey not being
21 allowed any visits, 76% only allowed partial access, and
22 only 1% had said that they were able to have full access
23 to visits from friends and family.

24 Were you aware of those results?

25 **A.** Yes, I've read that survey myself. I am aware of those
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1 results. And, you know, clearly that's very upsetting,
 2 especially given that our policies enabled visiting to
 3 take place. So you will see over the different
 4 revisions, how we have really worked really hard to open
 5 up Wales to having, you know, that opportunity of people
 6 seeing their loved ones.

7 **Q.** But in the case of people with learning disabilities, it
 8 seemed that that continued to have very long-lasting
 9 impacts?

10 **A.** Yes. No, I'm not disputing that for one moment, and
 11 that is something that all of us would want to, and
 12 should, you know, pay attention to on a number of
 13 fronts. Not just about pandemic planning, but in terms
 14 of engagement on any policy development.

15 **MS BEATTIE:** Thank you, my Lady.

16 **LADY HALLETT:** Thank you very much, Ms Beattie.
 17 Mr Heaney, that completes the questions that we have
 18 for you today. Thank you very much indeed for your
 19 help. I appreciate the burden it always places on
 20 people coming along to assist the Inquiry, so I'm very
 21 grateful to you.

22 I don't know if you're travelling back to Wales
 23 tonight?

24 **THE WITNESS:** No, I'm staying over this evening, my Lady.

25 **LADY HALLETT:** Oh, right, okay. Well, I won't ask what
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1 you're up to. Safe journey back when you go.

2 **THE WITNESS:** Thank you.

3 **LADY HALLETT:** Thank you very much.

4 I shall return to start again tomorrow at 10.00 am.

5 Thank you.

6 **(4.19 pm)**

7 **(The hearing adjourned until 10.00 am the following day)**

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