Witness Name: Rt Hon Mark Drakeford MS
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UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF THE RT HON MARK DRAKEFORD MS

I, Mark Drakeford, provide this first statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 7 June 2024 issued under reference M4/MarkDrakeford/01.

Preamble

1. I have acknowledged at the outset of each statement that I have provided to the Public Inquiry the unprecedented impact the pandemic has had on people across Wales. The pandemic touched the lives of everyone in Wales: my own, my colleagues, our communities, but none more so than the many families who lost loved ones, to those I express my sincerest of sympathies.

2. We could see how the pandemic was affecting people daily and we knew how important the vaccine and therapeutics were in unlocking our communities and our lives.

3. The vaccine roll out in Wales was a success because of the extraordinary efforts and commitment of the people of Wales, those in the Health Services who worked tirelessly in administering the vaccines, those in the military who supported the initial roll out but not least those who came forward for vaccination.

4. I met a number of individuals who were in the first priority group to be vaccinated. Many, especially those who had been shielding, venturing out for the first time to receive their vaccines. They told me that they felt the system was looking after

them. In my opinion, what really made the difference in Wales was the human spirit and public service ethos.

5. The success of the vaccination programme, translated into us not seeing large numbers of people failing seriously ill or needing hospital treatment. It weakened the link between infection and serious illness.

6. The information I have provided in this statement, is structured as follows:

    a. **Part A:** Introduction and overview of my role, and the relevant structure, people and processes in relation to vaccines and therapeutics (para 7)
    b. **Part B:** Development, procurement, manufacture and approval of Covid-19 vaccines (para 71)
    c. **Part C:** Vaccine deployment in Wales (para 81)
    d. **Part D:** Public messaging in respect of the Covid-19 vaccines (para 180)
    e. **Part E:** Barriers to vaccine uptake (para 209)
    f. **Part F:** Vaccine certification (para 219)
    g. **Part G:** Vaccine Safety (para 287)
    h. **Part H:** Vaccine Damage Payment Scheme (VDPS) (para 299)
    i. **Part I:** Therapeutics (para 300)
    j. **Part J:** Lessons Learned (para 304).

Part A: Introduction and overview

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

8. From 1991 to 1995, I was a lecturer in applied social studies at the University College of Swansea (now Swansea University). I then moved to the University of Wales, Cardiff, renamed as Cardiff University in 1999, as a lecturer in its School of Social and Administrative Studies. I was promoted to Senior Lecturer in 1999 and appointed as Professor of Social Policy and Applied Social Sciences in 2003.

I continued in post, alongside my political work, until my appointment as a Minister in 2013.

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

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

11. I remained First Minister until I tendered my resignation to the King on 19 March 2024. I was succeeded as First Minister by Vaughan Gething MS and subsequently by Eluned Morgan MS. I remain an elected member of the Senedd, representing Cardiff West and I was appointed as Cabinet Secretary for Finance and Welsh Language on 11 September 2024 by Eluned Morgan MS in her capacity as Prif Weinidog (First Minister).

Portfolio responsibilities

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

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

Decision-making principles of Welsh Government during the pandemic

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

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

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

17. In Wales, the Wellbeing of Future Generations (Wales) Act 2015 promotes equality as an objective for society, not just equality of opportunity. From the beginning, we saw the differential impact of the pandemic on different parts of society and quickly realised that many vulnerable people would be more severely impacted by all aspects of the pandemic. Wales started the pandemic already characterised by deeply entrenched health, economic and social inequalities. We sought, as far as we were able, to ensure that government action did not aggravate those inequalities and supported those approaches to reduce or reverse their impact, especially the approach to vaccine take-up.

Characteristics of Wales which affected decision-making

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

19. First, managing a government response for a population of three million is significantly different from decision-making for over fifty million. We were conscious of the distinctions between rural and urban areas, between more and less affluent areas and between North and South Wales. However, in the context of the pandemic, the evidence showed us that the key geographic differences were often between East and West Wales. We saw the effect of the virus spreading at different rates across Wales in a series of waves and patterns generally moving from east to west. Our response had to reflect this evidence. The smaller population was not, of itself, a sufficient condition for enabling things to work well, but it did allow us a greater ability to understand how the pandemic was making an impact (or was about to make an impact) in different communities and to work with local leaders across Wales to make decisions that were sensitive to the needs of different areas.

20. Secondly, the smaller scale (combined with technology) meant that we were able to set up calls with all necessary partnerships, for example, all local authority leaders or all NHS leaders at the same time in a way that would not be possible elsewhere. This was important in the context of the deployment of the vaccine roll out, so that we were able to link in with Health Boards and local authorities in a way that brought about swift and efficient vaccination hubs and identified and implemented remedies to issues that emerged during the course of the roll out such as reaching individuals in rural comities.

21. Thirdly, the relative stability of the political structures in Wales meant that we came into the pandemic benefitting from many longstanding personal and institutional relationships which had been built up over many years, where people had worked together on many common agendas and could use that human capital to sustain

key relationships. It meant that, when Welsh Ministers started having difficult conversations about challenging decisions, we were often in the position where there was rarely a single person in those conversations whom we did not already know and with whom we had not worked co-operatively on other matters. This commonality of approach applied across political parties. Cross-party co-operation is commonplace in the Senedd and working together across local authorities with differing political leadership is the norm in Wales, not the exception. There are also a number of partnership councils such as the statutory Partnership Council for Wales and the Third Sector Partnership Council, which meant that, from the beginning of devolution, people of different political persuasions representing different interests were around the table together.

22. The overarching Shadow Social Partnership Council became a very important vehicle during the pandemic. We expanded its remit and membership and radically altered its operations; rather than a formal quarterly meeting, it met much more frequently, sometimes weekly, for an hour, and focused on the most difficult decisions in front of us at the time. The Council had direct access to the Welsh Government's key advisers, such as the Chief Medical Officer for Wales, the Chief Scientific Adviser for Health and the Chief Executive of NHS Wales. The Council heard, in advance of publication, about how and why the Government was thinking of making decisions. Having listened to their views, decisions were adapted where good reasons for doing so emerged from that deliberation.

The effect in the pandemic of a unified NHS in Wales

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

24. By way of example, this unified system facilitated a whole-Wales approach to the rollout of the vaccine when it became available, ensuring that when supplies were

limited there was a managed and planned distribution across the seven Health Boards in Wales that enabled limited stock to be efficiently utilised.

The critical balance between lives and livelihoods

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

26. In striking that balance, consideration of the needs of the vulnerable and disadvantaged was central to our decision-making. Although we were conscious of the impact of restrictions on those who were healthy and economically secure, ensuring that we made decisions that would protect those most 'at risk' played a large part in our approach. This came into sharp focus early in the pandemic because of the emerging evidence of the differential impact of the pandemic on Black, Asian and Minority Ethnic communities. The evidence emerged from a small number of prominent clinicians who observed in their own practice that their Black, Asian and Minority Ethnic colleagues were more vulnerable both to catching the disease and to the more serious consequences of it. As Wales has a smaller network of clinicians, and a closer set of relationships between frontline workers and decision makers, they were able to alert the Welsh Government to their anxieties. A Black, Asian and Minority Ethnic Covid-19 Advisory Group was set up to examine the disproportionate impact of the virus on minority ethnic people and communities. Although the socio-economic subgroup looked at the broader context for the disproportionality, another subgroup produced a risk assessment tool which was exported to other healthcare systems and other workplaces. These actions were taken in recognition of the fact that many Black, Asian and Minority

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

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

Key Individuals and Bodies

28. Having set out above the background in which decision-making in the Welsh Government was taking place, I turn now to detail the key individuals and bodies with whom I worked in relation to matters falling within the scope of Module 4 and the manner in which the division of responsibilities lay between us.

Cabinet

29. Cabinet is the central decision-making body of the Welsh Government. It is a collective forum for Ministers to decide significant issues and to keep colleagues informed of important matters, which are discussed, either because they raise significant issues of policy or because they are of critical importance to the public. As the then First Minister for Wales, I chaired the Welsh Government Cabinet. Under normal circumstances, Cabinet meets once per week during the periods when the Senedd is sitting. The frequency of these meetings changed in the early period of the pandemic to enable a responsive approach.

30. After 23 March 2020, I also decided Cabinet should be a meeting of the whole Ministerial team and not just Cabinet members. Collective decision-making was a fundamental aspect of the Welsh Government process. During the fast-paced

developments in the early stages of the pandemic, I was anxious to find a way of ensuring that all major decisions (for example, in relation to the 21-day reviews of restrictions) were made collectively, involving as many of my Ministerial colleagues as was practicable. It concerned me that colleagues were bound by responsibility for decisions but were potentially not in the room when decisions were made. After 23 March 2020, we were all working from home. Although this brought challenges, it also created new opportunities. A conscious decision was taken that every meeting from there on should become a virtual meeting of the whole Ministerial team and not just Cabinet members. We continued that practice until I ceased to hold the office.

31. It mattered a great deal to me that, when we made difficult decisions, not a single Minister felt that they had not had every opportunity to test arguments or voice concerns about the conclusions arrived at. It meant that decisions were subject to the greatest possible scrutiny and that conversations that started with a variety of views coalesced towards a gradual, coherent conclusion that everyone was comfortable in supporting and defending. There were very rare occasions when no consensus emerged, and it was necessary for me to act as the first amongst equals. The infrequency of such instances demonstrated, I believe, the strength of our collective decision-making.

Senedd

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

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

c. the work of Senedd scrutiny committees, which produced several reports on the Welsh Government's pandemic response during the specified period;
d. oral questions to Ministers;
e. extended debates scheduled by opposition parties.

34. I appeared before the Senedd Committee for the Scrutiny of the First Minister on 3 July 2020, 22 October 2020, 11 February 2021, 16 December 2021 and 31 March 2022. I also gave evidence to the House of Lords Constitution Committee on 14 July 2021 and the Welsh Affairs Committee on 4 March 2021. The transcripts are exhibited in my Module 2 statement M2-Drakeford-01 at paragraph 203.

35. I was asked questions in respect of the vaccination programme in Wales during the scrutiny committee on 11 February 2021, exhibit **MD/003 - INQ000256946** refers. I was questioned about the assessment of the vaccine programme and the challenges ahead for delivering the vaccination programme. I confirmed that the I felt the vaccination programme in Wales had been a remarkable success story at that time and we were on track to complete the offer of vaccination to the top four priority groups by end of February 2021. There were a number of challenges we needed to consider particularly with regards to supply and demand for the vaccine. That said, we were able to maintain the supply of a vaccination and complete the offer of a vaccination during this period.

36. During the scrutiny committee on the 16 December 2021, exhibit **MD/004 - INQ000256947**, there was a discussion around the booster programme and walk-in vaccination centres. I was confident that the system we had in place for vaccine deployment was working well, while always being prepared to consider proposals for improvement in speed and reach.

Covid-19 Core Group

37. I set up and chaired a 'Core Ministerial Group' which consisted of the Ministers most involved in developing the pandemic response and key officials. It was for information sharing, rather than decision-making. It met weekly between 2 March and 14 September 2020. As a result of its limited lifespan in the context of the

relevant period, vaccination was not a material topic raised for discussion in this Group and so I do not reference it further here.

Daily Ministerial calls

38. From early April, I held regular daily morning calls at 9 a.m. with all Ministers. The purpose of the call was to ensure that the whole Ministerial team continued to operate together, sharing information and contributing to the process of decision-making. The fast-moving nature of the crisis, and the many ways in which problems required a response across different portfolios, meant that a daily call, at the start of each day, involving all Ministers proved invaluable in assisting responsive and collaborative decision-making. An email would usually be issued from my office, following the meeting, capturing the issues that had been discussed at the 9am call. Examples of this can be found in paragraphs 173,189 and 218 of my M2B statement.

Vaccination Update Meetings

39. A weekly meeting was established in January 2021 (and was reduced to fortnightly from 28 August 2021) to discuss the vaccine roll-out in Wales. I attended these meetings along with the Minister for Health and Social Services, the Chief Medical Officer the Director General / Chief Executive NHS Wales, the Chief Pharmaceutical Officer, policy colleagues and Special Advisors. In advance of these meetings, a vaccination update was circulated by the vaccination policy team. I have attached an example of the vaccination updates dated 18 January 2021 as exhibit **MD/005 – INQ000492762** and dated 6 April 2021 as exhibit **MD/006 – INQ000495968**. These meetings were an opportunity to consider the vaccination roll-out on a weekly basis. The meetings focused on the challenging issues and sought to agree key actions to address those matters. They provided direction to officials and assurance to Ministers. It was also an opportunity for me as First Minister to discuss issues relating to the vaccine, directly with the Minister for Health and Social Services and to discuss the approach to the roll out to include for example the vaccine strategies that we published in Wales. I was always very keen to speak directly with those persons involved in pandemic-related issues and these meetings provided an excellent opportunity to do so insofar as the vaccination process was concerned.

Division of Responsibilities between Ministers

40. As I have noted above collective decision-making was a fundamental aspect of the Welsh Government process and this approach was facilitated by the size of the Government and the nation, we were accessible to each other, and we talked issues through together. As First Minister, I had oversight across the Government but the dialogue that we had across the Ministerial portfolios was necessary to link the priority strands needed to achieve the outcome, which was to vaccinate the nation. It was only when the nation was vaccinated that we could safely move forward.

41. Individual Ministers were required to make decisions in their own portfolio responsibilities, thus underpinning good governance and prompt decision-making. I expected Ministers to exercise portfolio responsibilities themselves other than where: (i) a decision required a cross-government set of resolutions to the Cabinet for deliberation and agreement, and (ii) issues which were so significant that they needed to be elevated. It is for the respective Health and Social Services Ministers to comment upon the individual Ministerial Advice that they received and instructed upon during the relevant period.

42. As First Minister, I had the overarching responsibility for the formulation, development and presentation of Welsh Government policy. Where a decision was for me to make, then I would have received Ministerial Advice addressed to me, an example of which I exhibit as **MD/007 - INQ000145553**. I was also often copied in on Ministerial Advice sent to the relevant Minister and Deputy Minister for Health and Social Services, whose responsibility it was to make the decision. On such occasions, I would consider the advice and thereafter exercise my judgement to decide whether to intervene or not. I exhibit an example of an intervention at **MD/008 – INQ000495973.** Occasionally, I may have sent a message to the relevant Minister with my thoughts on the issue.

43. On a practical basis, my role as First Minister was to have oversight across all of the Welsh Government ministerial responsibilities. The individual strands of those portfolios all come together via the First Minister's office. As set out above, the respective Minister for Health and Social Services and I would attend many of the

same meetings and be involved with discussions with the same people regarding vaccination issues. Often, I would chair these meetings, and we would be jointly involved in receiving the relevant information, along with hearing from and discussing matters with those involved in the vaccination programme about the logistical matters. A key example of where this occurred is at the Vaccination Update meetings referred to above.

44. In terms of division of responsibilities, it would generally be a matter for the Minister for Health and Social Services to take the issue forward for decision-making purposes, whether that be by way of following the previously mentioned Ministerial Advice process or engagement with the relevant individuals or bodies on a practical and / or logistical basis. However, I would always have a strong sense of what decision the Minister was going to make as it would generally be a product of the discussions in which we were jointly involved, with the relevant officials and advisers.

45. An example of how this worked in practice can be illustrated by reference to the decisions made by the Minister for Health and Social Services, Eluned Morgan MS, regarding the vaccination of children. As the appropriate Minister, the eligibility decisions upon these issues were made by Eluned and I understand from those who have asked me to prepare this statement that she has addressed or will address these in her statement. However, those decisions were not made in isolation, but instead followed significant discussions between me, Eluned, and relevant officials and advisers in the Vaccine Update meetings. Such discussions involved consideration of the relevant challenges and the advice provided, including that of the Joint Committee on Vaccinations and Immunisations. Where appropriate, such discussions also involved other Ministerial colleagues. In this example, the views of the Minister for Education were sought due to the impact of the decision upon issues such as school attendance. Thus, whilst the decisions made firmly remained those of the Minister for Health and Social Services, the process leading up to those decisions involved a collegiate approach that rigorously had regard to and tested all of the relevant considerations and this was a process in which I was actively involved and engaged. I consider this way of working functioned well.

Other Key Individuals

46. In addition to the two Ministers for Health and Social Services who were in post during the relevant time, namely Vaughan Gething MS and Eluned Morgan MS, I also worked with Andrew Goodall (in his capacity as Director General / Chief Executive NHS Wales, Health and Social Services Group and as Permanent Secretary of the Welsh Government), Judith Paget (as she took over the role from Andrew Goodall), Sir Frank Atherton (as Chief Medical Officer), Dr Rob Orford (as Chief Scientific Advisor for Health), and my special advisor, Jane Runeckles. I also worked closely with Andrew Evans, the Chief Pharmaceutical Officer, who remains within the Welsh Government.

Funding arrangements in Wales for the Vaccination Programme

47. As indicated further below, there were limitations on the powers of the Welsh Government in respect of vaccines, therapeutics and medicines. As matters reserved to the UK Government, up to the point that the vaccine was ready to be deployed, there was no separate funding for the Welsh Government.

48. I am aware that, in the summer of 2020, discussions commenced on arrangements for the purchase of Covid-19 vaccines and antivirals. It was agreed on behalf of the Welsh Government that this would be undertaken centrally on a four-nation basis. In so agreeing, the Welsh Government chose to allow our consequential share of vaccine funding to remain with the UK Treasury in the central pool, with a Barnett share of the proceeds of the programme then guaranteed to Wales.

49. The specifics of these discussions took place between the then Minister for Health and Social Services, Vaughan Gething, and his counterparts in the other governments. I understand that he details the progression and outcome of such discussions within his Module 4 statement, and I respectfully refer the Inquiry to that statement without repeating matters here. Such matters are also detailed in the Welsh Government's corporate vaccine statement.

50. I am aware that, as a result of an agreement reached between the respective Health Ministers as to how vaccine supply would be shared between the nations,

a Memorandum of Understanding was put in place which provided that Wales would receive a share of the vaccine supplies in accordance with a Barnett formula calculation. This formula is a pre-existing one that is used by the UK Treasury to calculate the quantum of block grants for the Devolved Governments. Until 2018, this calculation was purely population-based. However, following the introduction of the new Fiscal Framework in 2018, a 'needs based' factor was included, which provided a small uplift to a purely population-based calculation.

51. Whilst this resulted in a more preferable outcome than had Wales' share of the supply been based upon a population share only, it still meant that there was the potential for vaccine supply shortfall in Wales in the early stages of the vaccine delivery.

52. As Wales has an older population than England, a disproportionately larger share of the Welsh population fell within the initial Joint Committee on Vaccination and Immunisation's priority groups and cohorts who were to be offered vaccinations at the outset. This meant that Wales needed its vaccine supply to be front-loaded. As a result of the agreement for the funding arrangements and purchasing to be undertaken centrally, there was no ability for the Welsh Government to seek to purchase its own additional supplies and we were therefore reliant on the distribution from the UK Government.

53. As I have detailed further below in paragraph 112, I raised this matter at a CDL call on 13 January 2021 and requested that Wales' share of the vaccine supplies be front-loaded so as to reflect the realities of how the intended roll-out strategies and priority groups would apply in Wales. Unfortunately, this request was a sophistication too far for the system to accommodate.

54. The vaccination milestones set by the Welsh Government were predicated upon sufficient supplies of the vaccine being available, with the only source of the vaccine being through the UK Government-led procurement exercise. We were reassured by the UK Government that supplies would be forthcoming but had no direct control over this. There were benefits to this approach in so much as it gave Wales much greater leverage with suppliers at a time when demand was

very high but production capacity and supply was constrained. The joint EU procurement demonstrates how other countries adopted similar approaches to maximise their presence in a highly competitive marketplace. It was not feasible for Wales to procure vaccines outside of the comprehensive UK-wide agreement led by the Vaccine Taskforce.

55. Vaccine supply was so constrained at the time that the programme simply operated on the basis of providing every dose we received to those who needed it most until such time as we stopped receiving supply of the vaccine. In that sense, there was no contingency plan. The plan was to give every next vaccine received to the next person at the greatest relative risk, reserving a second dose for that person to complete their course at an appropriate interval. Had vaccine supply ceased, people of relatively lower risk than those vaccinated would not have been given a vaccine at that time.

56. That said, we were able to put in place specific measures to mitigate the impact of the imbalance between population size and allocation by maximising the number of doses per vial. That approach represented our contingency plan.

57. Further, and whilst the original plan was to deliver all of the vaccine to Public Health England's distribution centre, there were concerns with this approach and the constraints this could place on deployment in Wales. On that basis, it was agreed that Pfizer would deliver Wales' agreed share of vaccines directly to distribution centres in Wales operated by the Welsh Blood Service. This is recorded in the Memorandum of Understanding between the Welsh Ministers and the Department of Business, Energy and Industrial Strategy, exhibited at **MD/009 – INQ000337321**. I am aware that more detail on this agreement is contained in the Welsh Government's vaccine corporate statement.

58. Fortunately, and as a result of Wales' utilisation of the additional dose from vials of Pfizer BioNTech vaccine in Wales, the decision by the UK Government not to front-load our supplies to match the vulnerability of the Welsh population did not compromise the roll-out of the vaccine in Wales. However, had we not learned how to minimise vaccine wastage so successfully, this would have potentially slowed the roll-out of the vaccination to the most vulnerable in Wales at the

outset. It also meant that we had to manage the efficiency of the scheme more closely than our counterparts in the UK Government and were considerably more risk-averse regarding vaccine wastage or inefficiency.

59. Had there been a need for the Welsh Government to escalate matters of vaccine supply at any time, I would have been able to raise matters with the Chancellor of the Duchy of Lancaster in a CDL call and I have detailed throughout this statement examples of vaccine-related issues being raised in this capacity. If necessary, I could also have raised such issues directly with the Prime Minister and / or raised them at COBR. In the absence of a scheduled COBR, I could have written to the Prime Minister to invite one to be convened and whilst this was not always successful as set out in my M2 statement, I would have endeavoured to communicate my concerns to the Prime Minister Alongside any escalation directly from me, there would also be options for escalation at a Chief Medical Officer level or official level, as appropriate.

60. Insofar as the funding of those matters for which the Welsh Government had financial responsibility, the decisions for those would fall within the portfolio of the Minister for Health and Social Services and the Minister for Finance and Trefnydd (or Local Government, as that office became post elections in May 2021). As indicated elsewhere, I would be routinely copied into those Ministerial Advice, but the decisions were those of the respective Ministers to whom they were directly addressed.

61. I do recall one particular Ministerial Advice into which I was copied in late-2020 regarding the financing of the initial roll-out of the Covid-19 vaccine programme for 2020-21. I exhibit this advice at **MD/010 – INQ000136856**. The issue at that time was that the UK Treasury had indicated to officials that the uplift provided to the Devolved Governments in November 2020 via the Barnett Guarantee included an allocation for deployment of the vaccine. However, there was a complete lack of clarity as to the amount of the allocation and as to the basis upon which it had been calculated. Further, and as the UK Government had, at that time, only committed to funding the vaccination programme in England until the end of 2020, there was no consequential funding for Wales. I have already addressed at length in my earlier statements to the Inquiry, and particularly in my Module 2B statement

exhibited above, how the funding arrangements between the UK Government and the Welsh Government during the pandemic impacted the Welsh Government's ability to respond. This was another occasion where greater clarity and advance notification of UK Treasury decisions would have assisted planning in the Welsh Government.

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

62. In general terms, the core decision-making of the Welsh Government was informed throughout by medical and scientific advice. Throughout the 21-day review cycle Ministers would meet directly with the Chief Medical Officer for Wales, the Chief Scientific Adviser for Health and other members of the medical and scientific advisory machinery. This would culminate in written advice to the Cabinet when core decisions were taken. Medical and scientific advisers attended Cabinet themselves. It was my practice to invite senior advisers to speak first in discussion of core decisions, so that Ministers always had access to the latest information.

63. Core decision-making was based on the best evidence available at the time. It is important to note not every piece of evidence points in the same direction and different sources of evidence cast a different light on the same subject. Every piece of evidence is capable of being contested. That is why Ministerial decisions were evidence *based* and evidence *informed* but could not be predetermined by any single evidence strand.

64. Specifically in relation to vaccinations, the Welsh Government was also in receipt of regular advice from the Joint Committee on Vaccination and Immunisation. The Chief Medical Officers of the four nations had agreed that the advice from the Joint Committee on Vaccination and Immunisation would be adopted across all four nations. This was not a new approach. It had been the long-standing policy of successive Health Ministers in Wales to accept the Joint Committee on Vaccination and Immunisation's advice, not solely in relation to pandemic-related issues, but as a much longer-term policy determination over many years preceding the relevant period.

65. In Wales, such advice was not binding and required Ministerial agreement. The provision of this agreement fell within the portfolio responsibilities of the respective

Minister for Health and Social Services. The Welsh Government was not a mere recipient of that advice. Elin Gwynedd, who was the Covid-19 Vaccination Deputy Director at that time, was the observer on behalf of the Welsh Government at the Joint Committee on Vaccination and Immunisation's meetings. Whilst the Joint Committee was ultimately responsible for determining the contents of any relevant advice, this provided the Welsh Government with the ability to engage with it prior to any such determination.

66. Further, and even once received, the Joint committee on Vaccination and Immunisation's advice would be fully considered and, where decisions were finely balanced, there would be ongoing discourse. For example, I am aware that there was ongoing discussion between the Chief Medical Officers and the Joint Committee on Vaccination and Immunisation regarding the decision to vaccinate healthy 12-to-15-year olds. Once more, I understand that Eluned Morgan, as the Minister for Health and Social Services with responsibility for making the decision to accept the relevant advice at that time, has detailed the considerations undertaken at that time in her Module 4 statement to the Inquiry.

67. Consideration of ethical advice was central to the Welsh Government's response throughout the pandemic. I have already referred to the Black, Asian and Minority Ethnic Covid-19 Advisory Group early in the pandemic, with the specific purpose of advising upon the impact of the virus on Minority Ethnic people and communities. I was aware of the likely disproportionate impact from the outset of the pandemic and so such matters were a particular priority.

68. Insofar as the vaccination programme was concerned, the ongoing consideration of such matters translated into vaccine equity was also very important. I have detailed in Part E below the steps taken to attempt to address any inequalities, including by way of the work done on an outreach basis.

69. I was also provided with regular updates from the Vaccine Equity Committee by Gillian Richardson at the weekly vaccination update meetings. Further, and whilst I was not a direct recipient of such advice, I was also aware of the existence of the Covid-19 Moral and Ethical Advisory Group (Wales) and understand that this

advice was fed by officials into the Ministerial Advice with which I was provided and / or copied into.

70. The approach taken to ethical advice may be best summarised by referencing its general underpinning of the Welsh Government's response to and decision-making in respect of the pandemic. It was always an ongoing consideration during the relevant period, including in respect of the vaccination programme and its roll-out to the people of Wales.

Part B: Development, procurement, manufacture and approval of Covid-19 vaccines

The Welsh Settlement

71. The regulation of healthcare professionals, medicines, vaccines and their authorisation, and vaccine damage payments are matters in respect of which legislative competence is reserved to the UK Government ("reserved matters"). The executive functions of Welsh Ministers can on occasion be wider than the devolved competence of the Senedd. For example, and insofar as relevant to the matters covered in this statement, in October 2020, the Human Medicine Regulations 2012 were amended to give the Welsh Ministers a limited role in a reserved matter, by the introduction of Regulation 247A. This provides that one of the conditions for broadening the category of healthcare professionals who could administer Covid-19 vaccines was that the Welsh Ministers (amongst others) had approved a protocol setting out certain requirements.

72. Accordingly, there was no formal role for the Welsh Government or Welsh Ministers within the vaccine regulatory and approval process. Further, and as set out in relation to the section on funding above, the procurement of the vaccines was also undertaken by the UK Government on a UK-wide basis.

Involvement with UK Government, Devolved Governments and other relevant bodies

73. I have outlined in substantial detail my engagement and interactions with the UK Government and the Devolved Governments in my first and second statements in Module 2, which I exhibit here as **MD/011 - INQ000273747** and **MD/012 - INQ000280190**, along with my M2B statement, which I have exhibited above. There were engagements at Ministerial level and official level across all Welsh

Government portfolio areas, although I and other Ministers would not be privy to the full details relating to levels of engagement between officials.

74. Insofar as operational readiness for vaccine development and deployment, development, procurement, manufacture and approval of Covid-19 vaccines, I had limited involvement with the UK Government. Whilst in many aspects of the pandemic, I was involved with much of the outward inter-governmental communication, insofar as vaccines were concerned, this was generally undertaken by the respective Minister for Health and Social Services (where appropriate, bearing in mind the specifics of the devolved settlement) and their relevant counterparts in the other Governments.

75. I understand that Vaughan Gething MS, has set out in his statement the role of the Medicines and Healthcare products Regulatory Agency (MHRA) which is the regulator for medicines, medical devices and blood components for transfusion in the United Kingdom. This includes all relevant vaccines and therapeutics in respect of Covid-19. I had no direct contact with the Medicines and Healthcare products Regulatory Agency.

76. Similarly, I had no direct contact or involvement with the Covid Vaccine Taskforce. I understand Vaughan Gething has also set out the role that this Group took during the relevant period.

77. As I set out in my Module 2 statement to the Inquiry, the principal platforms for four nations engagement in which I was involved were COBR and, from May / June 2020, I also had regular discussions with the Chancellor of the Duchy of Lancaster, the First Minister of Scotland and the First Minister and deputy First Minister of Northern Ireland. I have referred to these informal meetings as "CDL calls" throughout this statement. These meetings were intended as an information sharing forum and became the primary four nations Ministerial meeting from that time. There were several occasions when the topics discussed at the CDL calls included issues relating to vaccination and I have set out those which were relevant throughout the body of this statement.

78. In considering the sufficiency of involvement in decision-making relating to the development of vaccinations, a distinction must be drawn between the vaccination programme and other areas of inter-governmental relations. This was an area where I consider contact with the UK Government was generally good. In contrast with other aspects of the pandemic response, the division of responsibilities between the respective governments was clear-cut. Once the formula for dividing the supply of the vaccines had been agreed, it was for the respective Governments to deploy the vaccine.

79. Discussions were had between the respective governments and experiences would be shared, particularly regarding operational challenges such as vaccine hesitation and different initiatives, but these were not challenges to or clashes of differing policies. Once the sharing formula was set, the information sharing that took place on the successful approaches to implementation was worthwhile.

80. In those circumstances, I do not consider there is necessarily significant room for improvement. Whilst it was not entirely without issue, any delays were dealt with and there were very good levels of involvement and communication at official level which meant there was sufficient engagement between the relevant persons in the respective governments. Andrew Evans, as Chief Pharmaceutical Officer, was particularly important in this role and was always aware of any such matters arising.

Part C - Vaccine deployment in Wales

81. Until such time as a vaccine was available, the Welsh Government adopted a programme of non-pharmaceutical intervention which I have set out comprehensively in my M2B statement. All the modelling work showed us that as restrictions were eased, the virus would return to wider circulation, at whatever point the easements happened. It was never a realistic or sustainable option for the Welsh Government to continue severe restrictions without easement until a vaccine became available, because such an approach would have collided with the ability to persuade people to comply with restrictions. We appreciated the impact that these restrictions were having on people, their lives and livelihoods – whilst we had an overarching duty to protect the health and wellbeing of the nation,

the rights of our citizens were also a paramount consideration. However, the roll out of the vaccine programme was the key to unlocking the nation.

Preparedness to vaccinate in Wales

82. At the commencement of the relevant period, I consider Wales had a well-functioning, well-tested and well-led vaccination programme in place. This was developed upon for the pandemic and resulted in a successful vaccination programme which has reformed vaccinations in Wales. Throughout the tenure of my various positions held in the Welsh Government, I have always been proud of the vaccination record in Wales and our ability to reach the Welsh population to engage in vaccination programmes. I consider vaccination in Wales to be one of our wealth inequality weapons, with vaccine take-up amongst the more disadvantaged communities usually being highest.

83. The Covid-19 vaccination programme did not exist in a vacuum. There is Ministerial involvement each year with the flu vaccination programme and Ministerial decisions regarding vaccination-related matters such as eligibility and how vaccination take-up may be promoted amongst those eligible is something that is frequently grappled with by the relevant Ministers.

84. The Welsh Government also had prior experience with targeted vaccination programmes, such as the human papillomavirus (HPV) vaccination programme against cervical cancer for adolescent girls, which was introduced in 2008, and an extension of further targeted HPV vaccination programmes in 2017 and 2019/20 onwards for men and adolescent boys.

85. From the start of the pandemic, the race was on to establish an effective vaccine. When it became available in Wales, we were able to draw on our long and successful history of vaccine deployment. The accumulated knowledge allowed us to plan and prepare for the practical issues of distribution, deployment, workforce preparation, patient contact, responding to inequality issues and many more.

86. During the relevant period, and as a result of that pre-existing knowledge, I sought to ensure that the existing preparedness was built upon ahead of the availability of a Covid-19 vaccine. On 7 April 2020, at a meeting with the Minister for Health and

Social Services, I asked for work to start on how a vaccine should be distributed when it was available. The Chief Medical Officer confirmed that he would ask Public Health Wales to draw up plans, exhibit **MD/013 – INQ000349283** refers.

87. The minutes of a Covid-19 Core Group I attended on 8 April 2020 record that, at that time, a vaccine was not expected to be available until the end of the year at the earliest. I exhibit these minutes at **MD/014 – INQ000311826**.

88. On 24 April 2020, I published *Leading Wales out of the Coronavirus pandemic: A Framework for Recovery,* exhibited as **MD/015 - INQ000349353**. This document set out the evidence, principles and the public health approach that the Welsh Government would apply when considering whether / how to lift restrictions and was detailed in my Module 2B statement. Materially for this module, the framework recognised that once a vaccine was available, surveillance would need to shift to monitoring vaccine impact, uptake, vaccine failures and adverse events, changes in epidemiology and strain variation in the virus, and control of outbreaks. In order to deliver this strand of the framework, Public Health Wales was to lead the design and implementation of a Covid-19 surveillance system.

89. At a meeting of Cabinet on 4 May 2020, the collective view was that it was important to identify all the priority interventions that would need to be funded in response to dealing with the pandemic, particularly given the concerns over a lack of communication from the UK Government as to the extent of consequential funding at that time. Such interventions were identified as including resources for any vaccine made available in due course. The minutes of that meeting are exhibited at **MD/016 - INQ000048790**.

90. At a Covid-19 Core Group meeting on 14 July 2020, exhibit **MD/017 – INQ000312134** refers, we were advised that the Health Boards' plans for the winter were being considered with a particular emphasis on contingency planning and the vaccine programme.

91. At a Cabinet meeting on 18 August 2020, it was confirmed that work was continuing on the development of a vaccine, with the possibility that one may be available sometime in the autumn. However, limited supply was anticipated, exhibit **MD/018 - INQ000048862** refers.

92. At that time, consideration of the Health Boards' plans for the winter were continuing, with a particular emphasis on contingency planning and the vaccine programme as the minutes of a Covid-19 Core Group meeting on 25 August 2020 demonstrate. Those minutes are exhibited at **MD/019 - INQ000311836**.

93. Pfizer BioNTech was granted temporary authorisations by the Medicines and Healthcare products Regulatory Agency on 2 December and, on 30 December 2020, the Oxford-AstraZeneca vaccine was approved for use in Wales and across the UK.

94. On 8 January 2021, the Moderna vaccine was granted a temporary authorisation with a conditional marketing authorisation being granted on 31 March 2021, ahead of its inclusion in the UK vaccination programme in April 2021.

95. The vaccine came sooner in the relevant period than originally expected and, when it did, Wales was prepared for roll-out. We vaccinated when the vaccine became available and did that very quickly. The preparedness of our existing vaccine programme is most clearly demonstrated by the speed at which the Covid-19 vaccination programme was deployed, the specifics of which I have set out by way of a chronology of the vaccine roll-out further below.

Vaccine roll-out in Wales

96. On 2 December 2020, the same day that Pfizer BioNTech was approved for use in Wales and across the UK, then Minister for Health and Social Services, Vaughan Gething, issued a Written Statement concerning its deployment in Wales. This Written Statement was noted in a Cabinet meeting later that afternoon, along with the hope that the programme of vaccination could begin as early as the following week. The minutes for that meeting are exhibited at **MD/020 - INQ000048788** and the Written Statement at **MD/021 – INQ000495958**.

97. The vaccination programme commenced on 8 December 2020. To mark this occasion, the Minister for Health and Social Services, Vaughan Gething, and I issued a joint Written Statement to the press setting out that we would be working

hard to deliver the vaccine in Wales. I exhibit this at **MD/022 – INQ000495976**. As I stated, Wales was the first country in the world to receive supplies of the Covid-19 vaccine the week before and, on 8 December, became one of the first countries to begin the roll-out of the vaccine to its population.

98. An updated Coronavirus Control Plan was published on 14 December 2020, exhibited as **MD/023 - INQ000227576**. In the foreword both myself and the then-Minister for Health and Social Services recognised that the approval of the first Covid-19 vaccine earlier that month, and the promise of more to come, coupled with the start of our vaccination programme in the last week, had been a genuine breakthrough in the pandemic which brought with it promise of a brighter future in 2021. The Control Plan acknowledged that the process of vaccinating everyone would take time; it would be a while before the benefits of the vaccination programme were seen and the roll-out needed to continue in tandem with other restrictions.

99. The Control Plan set out that the initial focus of the roll-out would be protecting the most vulnerable to reduce hospital admissions and deaths and this was why, like the other UK nations, the Welsh Government was following the advice of the Joint committee on Vaccination and Immunisation, which recommended that the first priorities should be the prevention of Covid-19 mortality and the protection of health and social care staff and systems. We had already started vaccinating those priority groups but that needed to be completed before the vaccine could be delivered to the rest of the population. The Control Plan confirmed that the roll-out would be re-evaluated when more was known about the impact of the vaccination programme, and this would be done in line with testing and other scientific advancements in our then understanding and treatment of coronavirus.

100. On 30 December 2020, and as detailed above, the Oxford-AstraZeneca vaccine was approved for use in Wales and across the UK by the Medicines and Healthcare products Regulatory Agency. The key context for decisions of the Welsh Government altered with the arrival of effective vaccines. From there onwards, so much of our policy effort, practical action and communication with the Welsh public revolved around making the best possible use of the opportunity provided by vaccination.

Covid-19 Vaccination Strategy

101. The then Minister for Health and Social Services published the National Vaccinations strategy on 11 January 2021. Updated strategies were subsequently published on 26 February 2021, 23 March 2021, 7 June 2021 and October 2021. A further strategy was published in February 2022. The strategies followed the recommendations of the Joint committee on Vaccination and Immunisation and the respective Ministers for Health and Social Services in post at that the relevant time were ultimately responsible for the publication of those strategies. However, in accordance with the Ministerial working relationships in Wales already outlined above, various iterations of the strategies would have been discussed between me and the then Minister for Health and Social Services prior to publication at the weekly meetings. Further details on these strategies are, I am informed, set out in the witness statements of Eluned Morgan MS and Vaughan Gething MS.

Eligibility and prioritisation decisions

102. Insofar as decisions in Wales on eligibility and prioritisation, as set out above, there was a commitment between the four nations to follow the advice of the Joint Committee on Vaccination and Immunisation.

103. The responsibility for the formal consideration of the eligibility and prioritisation decisions and whether the Joint Committee on Vaccination and Immunisation's advice should be adopted was that of the respective Ministers for Health and Social Services. Such decision-making went through the Ministerial Advice process. The advice was prepared by relevant officials and routinely included clinical advice from the Chief Medical Officer, Chief Pharmaceutical Officer and Chief Nursing Officer.

104. As set out above, I would often be copied into the advice sent. This provided me with the opportunity to raise any issues during the pattern of meetings already set out. However, the decisions on eligibility and prioritisation were those of the Ministers for Health and Social Services. I understand both Ministers have set out the various advice received in their respective statements, and I do not intend to rehearse the same in this statement. However, I provide some examples

of the advice in respect of which I was asked for input and / or expressed a particular view in response.

105. On 20 July 2021, I was copied into advice to the Minister for Health and Social Services in relation to a proposed Primary Care Covid-19 Immunisation Scheme (PCCIS) for Pfizer-BioNTech vaccine. The Minister for Health and Social Services considered and agreed the recommendation in the advice but, in so doing, raised the potential for a perceived (although not actual) conflict of interest arising from her husband's employment as a GP and accordingly sought my oversight. On 22 July 2021, I considered this advice, and the response of the Minister for Health and Social Services. I confirmed the importance of this advice to assist in the vaccination programme and indicated that I was of the view that there was no reason why the Minister could not take the decision, given that the nature of the recommendation applied to the entirety of the primary care sector and had no impact upon an individual practice or individual clinician. I exhibit this e-mail chain at **MD/024 – INQ000495972**.

106. On other occasions, my observations would simply request further information from officials as a result of actions arising for me to undertake from the decisions made by the Minister for Health and Social Services. For example and following agreement by the Minister on the acceptance of the Joint Committee on Vaccination and Immunisation's advice for the vaccination of children in early-August 2021, I noted the advice as a copy recipient and sought some further information and / or supporting material ahead of a forthcoming press conference to permit me to better explain what the Welsh Government was doing to implement the Joint Committee's advice. I exhibit my response to this advice at **MD/025 – INQ000495974**.

Four nations liaison and ongoing roll-out / prioritisation and eligibility

107. As the vaccine was not available, the early COBR meetings made little mention of vaccinations. By the time of the COBR meeting held on 22 September 2020, exhibit **MD/026 - INQ000083849** refers, the four Chief Medical Officers of the UK had agreed that the whole of the UK should move to alert level 4. Whilst more stringent restrictions were required at that time and circumstances would be

particularly difficult over winter, it was noted that there was good reason to be optimistic about having a vaccine in the next year.

108. As detailed earlier in this statement, the main forum for vaccine-related inter-governmental communication in which I was involved came in the CDL calls. I have set out those calls which were material throughout this statement. These calls turned to vaccination as a substantive topic on 6 January 2021, in which the UK Government reaffirmed commitment to the Barnett-share distribution of vaccinations. There was a general recognition that the distribution and roll-out of vaccines would be subject to intense scrutiny and I emphasised that it was essential for there to be clarity and certainty of supply.

109. At this meeting, all four nations agreed a commitment to the Joint Committee on Vaccination and Immunisation's priority list. There was a discussion over the prioritisation of certain professions and the Deputy Chief Medical Officer for England had robustly defended the protocol for the vaccination programme and the priority groups it identified In particular, attention was drawn to the argument that the vaccination of 43 people in care homes would save one life, whereas there would be a need to immunise 62,000 teachers under the age of 30 to achieve the same result.

110. The outcome of this call was reported to Cabinet in the meetings on 6 and 7 January 2021. I exhibit the note of the CDL call at **MD/027 – INQ000256889** and the minutes of the Cabinet discussion at **MD/028 - INQ000057757**.

111. As set out above, the Moderna vaccine was granted a temporary authorisation on 8 January 2021, although its inclusion in the UK vaccination programme did not occur until April 2021.

112. On 13 January 2021, I attended a CDL call where much of the discussion focused on vaccination and which I refer to at paragraph 53 above. Emphasis was placed upon close joint working between the four nations. Discussions turned to the distribution of the vaccines in accordance with the Barnett formula and I raised concerns over the risk that supplies would not address the needs of the older population and the consequent increased size of the priority cohorts in Wales. The

differences in demographics was acknowledged and Ruth Todd (who was the lead on vaccine supply for UK Government) said that the Devolved Nations would receive enough vaccine to enable the vaccination of priority groups one to four in a consistent timescale. The note of the call suggests that the impression taken from this meeting was that the Barnett distribution would be adjusted for age. However, whilst I expressed my thanks at the meeting for the acknowledgement that Wales had a higher percentage population in the top four cohorts, it was not my impression that there was likely to be an adjustment to the supply of vaccines to Wales as a result of it. I exhibit a note of this call at **MD/029 – INQ000495959**. As I have already set out above, there was no adjustment to the supply received in Wales to account for the increased cohort sizes. However, for the reasons already outlined, this didn't prevent the vaccination programme in Wales from proceeding as intended.

113. On 18 January 2021, during a BBC Radio 4's Today programme I was asked about the vaccine roll out in Wales and the suggestion that Wales had vaccinated fewer proportion to its population than other nations of the UK. I explained that there was a very marginal difference in the vaccination statistics but in any event, I explained that the supplies of the Pfizer vaccine had to last until the beginning of February and would not be used all at once. I explained that it would be logistically damaging to use the vaccine all in the first week and the sensible thing to do was to vaccinate over the period that we had to vaccinate, so that the system could absorb it. At no time was the Pfizer vaccine withheld. All Health Boards were received doses of Pfizer which were successfully deployed in a manner to minimise wastage, which at that time was less than 1%. I committed to vaccinating all four priority groups by the middle of February and this was achieved.

114. I understand that the then Health Minister, Vaughan Gething MS entered into correspondence on this issue with Dr David Bailey, Chair of the British Medical Association Wales, on the deployment of Pfizer. In his letter of 15 February 2021, the Minister highlighted that we were following the latest scientific advice as we had done throughout the pandemic. This included the advice of all four nation Chief Medical Officers who had agreed with the Joint Committee on Vaccination and Immunisation's advice that we should prioritise giving as many people in at-risk

groups their first dose, rather than providing two doses in as short a time as possible. That letter is attached as exhibit **MD/030- INQ000492064.**

115. Vaccine roll-out was further discussed at a CDL call on 20 January 2021, to which exhibit **MD/031 - INQ000216570** refers. At this meeting, I called for joint working on messaging about vaccinations and for a discussion about the next phase of prioritisation. It was noted that there was a risk that a triumphalist tone in messaging would undermine restrictions, when advice from SAGE remained very sobering. It was agreed that there was a need to temper messaging, whilst taking pride in NHS achievements.

116. On 26 January 2021, during First Minister's questions in the Senedd, I was asked questions regarding the vaccine roll-out, including in relation to the priority status of unpaid carers and the vaccination figures for the over-80s. As to the former of these questions, I confirmed the commitment made by the First Ministers and Prime Minister to abide by the Joint Committee on Vaccination and Immunisation's advice. While individual cases could be made for amendments to the list, I confirmed that the advice of the Joint Committee should be followed. Concerns were raised that there had been a large number of missed appointments over the preceding days from people in the 80-plus range as a result of inclement weather and that they did not feel safe to leave their homes. I accepted during that session that we did not reach the aim of vaccinating 70% of the over 80's within the original timeframe because of this interruption to the programme and that people over 80 should not be pressurised to come out to be vaccinated when they themselves had decided it was not safe to do so but despite the weather interruptions, we were still on track to offer a vaccination to everybody in the first four priority groups by the middle of February of 2021. Working with Public Health Wales, we had sought to ensure that the vaccination infrastructure was as resilient as possible, but it was continuing to develop at this stage.

117. However, I emphasised that all of those who were not able to attend had been offered further appointments by the end of the following day and so the number could be made up rapidly. I emphasised that the existing ambition to offer vaccination to all people in the top four priority groups by the middle of February

remained achievable. I exhibit the transcript of this plenary session at **MD/032 – INQ000493739**. I also exbibit, as **MD/033 - INQ000401712** the vaccine strategy published on 26 February 2021 in which it was confirmed that the first milestone had been achieved in that a vaccine had been offered to everyone in the first four priority groups. The updated strategy confirmed that the vaccination infrastructure and capacity had continued to grow in Wales, with vaccines being administered from almost 500 locations to include mass vaccination centres, GP practices, hospital sites and mobile units and with increased capacity expected going forward with the role of community pharmacies. As far as I am aware, no other targets were missed.

118. The time we invested at the start in making sure our vaccination systems were working properly meant that our vaccination rates exceeded other UK nations and continued to do so thereafter. During First Minister's questions in the Senedd, which is exhibited above, I explained that the number of vaccinated people in Wales had increased from 162,000 to 290,000 people in one week alone. That was the speed of the rollout in Wales, a speed that was urgent, a speed that was dedicated and a speed that was succeeding.

119. Cabinet met on 16 and 17 February 2021, exhibit **MD/034 - INQ000057770** refers. The Chief Medical Officer for Wales advised that the situation in Wales was improving and that 780,000 people in Wales had received their first dose of the vaccine.

120. On 19 February 2021, the Welsh Government published an update to the Coronavirus Control Plan: alert levels in Wales (coming out of lockdown), which I exhibit as **MD/035 - INQ000081858**. Both I and the Minister for Health and Social Services wrote in the foreword that the vaccination programme had gone from strength to strength, although we continued to advocate caution given the emergency of new variants.

121. The updated Control Plan confirmed that the take up at the time of publication was very high, exceeding the 80% target set for the first four groups of the vaccination roll-out. Some priority groups had exceeded 90% take-up. We

were, however, continuing to address concerns about lower levels of take-up amongst some groups and were working actively with communities where this might be the case. I have detailed the work carried out in these communities later in this statement.

122. The Plan set out our commitment to ensure that nobody would be left behind and the NHS would be following up with people who had not yet been vaccinated to make sure that they had further opportunities to take up this important protective offer. As we were to move ahead with vaccination, it was confirmed that the Joint committee on Vaccination and Immunisation's advice would continue to be followed, as it considered the next groups to be prioritised.

123. Updates were provided on vaccine roll-out at the CDL calls on 22 February 2021, exhibit **MD/036 – INQ000256892** refers, and again on the 24 February 2021 exhibit **MD/037 – INQ000256895**, refers. At the latter, I voiced my strong support for the continued abidance by the Joint Committee on Vaccination and Immunisation's advice on phase two prioritisation. I emphasised that four nations support for this was essential as divergence would undermine the entire approach. The Chancellor of the Duchy of Lancaster echoed this view and it was agreed that the respective Health Ministers for the four nations would consider this with a view to a joint statement.

124. I also raised questions about the security of the supply of vaccines following a slippage in the previous weekend as a result of a quality release delay. It was understood that the next batch was to be short-dated which made timely delivery even more important. It was proposed that the UK Government's Vaccines Minister would join the call the following week to cover these issues.

125. That call happened on 3 March 2021 when the Vaccines Minister confirmed that the delivery schedule was then known until the end of April. I raised my concerns directly with the Vaccines Minister regarding the supply profile as it was due to soon rise to supply for 250,000 a week, with the following week only being 60,000, which was likely to create an issue in 12 weeks' time with second doses. My view was that the sooner we could resolve such matters, the better. It was also at this meeting that I updated the other nations on the work being undertaken with

vaccine hesitancy in Wales to focus on engaging community leaders and clinicians from specific backgrounds, alongside our 'never too late' campaign. I exhibit a note of this call at **MD/038 – INQ000495960**.

126. As the spring developed, the vaccination programme made good progress and the number of infections continued to fall to a point which was described by the Chief Medical Officer for Wales as "relatively benign". This meant that, over the coming months, restrictions could be relaxed progressively.

127. During the CDL call on 17 March 2021, a further discussion was had about vaccine supply disruption. I stressed the difficulty that any disruption would cause to the roll-out in Wales and sought to ensure that any disruption to supply was being borne equally by the four nations. I was assured that distribution was occurring in accordance with the Barnett formula. UK Government modelling was still being worked through, but the mid-April target (that being, to offer the vaccine to all current priority groups by that date) was considered still to be achievable. I exhibit a note of this call at **MD/039 - INQ000216572**.

128. During Cabinet on the 29 March 2021, exhibit **MD/040 - INQ000022532** and exhibit **MD/041 - INQ000057798** refer, we were advised that in terms of the vaccination programme, it was likely that Milestone 2, being those within groups 5-9 were to be offered their first dose by the middle of April and achieving 75% take up across the groups, would be met by the end of that week. Overall, the public health situation in Wales continued to improve.

129. During Cabinet on 19 April 2021, exhibit **MD/042 - INQ000129892** and **MD/043 - INQ000129893** refers, we were advised that the vaccination programme continued quickly, with almost 50% take up of first vaccinations for the 40-49 age range. However, the extent to which it had broken the link between community transmission and direct Covid-19 harms was not yet clear, with concerns over transmission of new variants of the virus. Cabinet continued to adopt a cautious approach to non-pharmaceutical interventions, whilst rolling out the vaccination programme.

130. During April 2021, CDL calls concentrated largely on the issue of certification insofar as the vaccination programme was concerned and I have referenced those in the relevant section further below.

131. At Cabinet on 3 June 2021, exhibit **MD/044 - INQ000022537** refers, restrictions were relaxed progressively, which was done in the knowledge that the adult population of Wales was expected to have been offered both doses of the vaccine by mid-July. However, the move to alert level 1 was not fully implemented, because, as discussed by Cabinet on 16 June 2021, exhibit **MD/045 - INQ000057745** and **MD/046 - INQ000057836** refers, the Delta variant was causing exponential growth in infections and there was a need to monitor the effect of the variant. The resurgence of cases was most marked in younger age groups, which was a reflection of transmission among those who were least likely to have had the benefit of vaccination at that stage and who experienced higher levels of social mixing. Whilst older age cohorts were not exempt from infection, rates amongst them were lower and there was likely to be some protective effect from the vaccination programme. The Chief Medical Officer had indicated that delaying further the lifting of restrictions for a short period would enable a greater proportion of adults to take up the offer of a second dose of the vaccine.

132. In a CDL call on 9 June 2021, it was recognised that all four nations were in a similar position, with the vaccine weakening but not breaking the link between case numbers and hospitalisation. A note of this call is exhibited at **MD/047 - INQ000216588**.

133. By the time of the CDL call on 14 June 2021, to which exhibit **MD/048 - INQ000216589** refers, there had been a rise in infections driven by the Delta variant with the vaccine having less effect upon it (particularly at one dose), although the vaccine was continuing to have an impact on the relationship between the variant and hospitalisations. Updates provided on the roll-out confirmed that the vaccination programme had very high levels of coverage in older and more vulnerable groups for both doses, with second doses being fewer for the younger age groups. As of that day, Wales had offered the first dose of the vaccine to all adults aged 18 and over in Wales, half of people in their 50s and a third in their 40s had had their second doses.

134. On 5 July 2021, exhibit **MD/049 - INQ000129963** refers, Cabinet decided to create an alert level 0 in the Coronavirus Control Plan, to maintain some public health measures to keep the virus at manageable levels, until the vaccination roll-out was complete, as recommended in the paper, exhibit **MD/050 - INQ000129964** refers.

135. At Cabinet on 14 July 2021, exhibit **MD/051 - INQ000129973** refers, it was agreed that self-isolation rules should remain in place for those 18 and over who had not yet been fully vaccinated. It was suggested that keeping this requirement in place might encourage a greater take up of the vaccine.

136. During Cabinet on 2 August 2021, exhibit **MD/052 - INQ000057896** refers, Ministers were advised that in terms of the vaccination programme, as of 22 July, 90.1% of adults in Wales had received their first dose, and 78.8% had received their second dose, which equated to more than 2 million people. It was anticipated that 80% of adults would have received their second dose by 29 July 2021. The vaccination programme was working, with the intention of offering all adults their second dose by the end of September. Significant efforts were underway to ensure nobody was left behind and Cabinet requested a note on the autumn booster programme, planning for which was underway.

137. At the same meeting, Cabinet confirmed that it opposed the action of the UK Government to incentivise the roll-out of the vaccination programme to young people in England, as there was a concern that this could lead to people delaying their inoculation until such rewards were available. The focus of the vaccination programme in Wales was social responsibility and taking precautions to protect the wider society.

138. The requested note in respect of the autumn booster programme was provided to Cabinet by e-mail on 5 August 2021. The note confirmed that the Joint Committee on Vaccination and Immunisation had published interim advice on the Covid-19 booster vaccination programme, which aimed to reduce any further incidence of Covid-19 and maximise protection in those who were most vulnerable to serious infection, ahead of the winter months. It was agreed that the Covid-19

Programme and Health Boards undertook planning to begin the booster programme in early-September 2021. This note is exhibited at **MD/053 - INQ000495975**.

139. At a CDL call on 8 September 2021 following summer recess, general updates from the four nations were provided. In Wales, I emphasised that Cabinet was focused on three immediate actions, following the Joint Committee on Vaccination and Immunisation's advice: the autumn booster campaign, vaccination of 12–15-year-olds and considering the vaccine certification (which I return to later in this statement). Insofar as the autumn booster campaign, there was some frustration at that time regarding the pace of the Joint Committee's decision-making which was holding back the roll-out of the boosters in care homes in Wales.

140. Heading into the winter, the Omicron virus emerged as a variant of concern. The Chief Medical Officer for Wales had advised me that it was more transmissible than any previous variant and we needed to see how it would respond to the vaccine. By the end of November, it was likely that there was already community transmission in England, but not necessarily in Wales. Such was my concern about the Omicron variant, I, together with the First Minister of Scotland, wrote to the Prime Minister asking for a COBR meeting to be convened. This letter is exhibited at **MD/054 - INQ000256922**.

141. At Cabinet on 29 November 2021, exhibit **MD/055 - INQ000130006,** Ministers were advised that the Joint Committee on Vaccination and Immunisation was expected to recommend an acceleration of the vaccine programme across the UK later that afternoon in response to the variant. Plans had already been drawn up in anticipation of that advice the previous weekend, with the aim of increasing the number of people receiving boosters from 128,000 to 300,000 a week. The booster was to be extended to all adults and the gap between the second dose and booster was to be reduced from six to three months. In addition, those who were immune-suppressed would be offered a booster three months after their third primary dose and all 12-15-year-olds were to be eligible for a second dose. A copy of the Joint Committee on Vaccination and Immunisation's advice was provided in

those terms and is exhibited at **MD/056 - INQ000480021** and was thereafter agreed under Ministerial Advice by the Minister for Health and Social Services.

142. The COBR meetings materialised on 10, 15 and 19 December 2021. At the meeting on 10 December, the Chief Medical Officer for the UK Government confirmed that there was evidence around rapid growth and a high attack rate from Omicron, which was able to infect those with two vaccines. There remained uncertainty as to whether two doses of the vaccine could reduce the likelihood of severe disease at that time. UK Health Security Agency data referred to in the meeting suggested that the protection against Omicron infection provided by two doses of the AstraZeneca vaccine was limited or non-existent, and so there would need to be consideration of whether there should be prioritisation in the booster programme of those who had received that vaccine. The Pfizer-BioNTech vaccine was assessed as having slightly higher efficacy at approximately 20 per cent for symptomatic disease. Minutes of that meeting are at **MD/057 - INQ000083854**.

143. At the COBR meeting on 15 December 2021, the Chief Secretary to the Treasury was invited to provide an update on funding. He confirmed that up-front funding for the vaccine roll-out was being provided to the Devolved Governments. Devolved funding was to be reviewed before Christmas and on a regular basis thereafter, with a reconciliation process to ensure funding was kept in line with the Barnett process at a later date. The view of the Devolved Governments at that time was that the funding offered was accelerated money already budgeted for, rather than entirely new money. The undesirability of having to wait for money to be decided on by Westminster was raised as each Government had separate responsibilities to take measures to protect public health. Minutes of the meeting are exhibited at **MD/058 - INQ000083855**.

144. By 16 December 2021, concern was rising about the potential of the new Omicron variant, and Cabinet decided to re-introduce into regulations a requirement to work from home with guidance across government to be strengthened, exhibit **MD/059 - INQ000057970** refers. In making that decision, the co-chair of the Technical Advisory Group informed Cabinet that the current trajectory of infection from Omicron was high and fast with the peak expected around the third or fourth week of January and that there was the issue of vaccine

escape, with some suggestion that the effectiveness of the booster would wane after eight to nine days.

145. In the run-up to Christmas there was a COBR meeting on 19 December 2021, exhibit **MD/060 - INQ000083852** which I attended. The minutes record that the booster vaccination programme had progressed well to date with approximately 50% of the UK population having received their booster vaccine. The Chief Medical Officers confirmed that it remained uncertain to what extent the booster vaccination campaign would protect the public from infection and severe illness.

146. We specifically asked whether the UK Treasury was planning to extend further financial support to the Devolved Governments, and we were advised during that meeting that the UK Government was going to uplift funding to support the United Kingdom's response to the pandemic. We were further advised that additional funding provided to the devolved governments would need to be paid back to the UK Treasury, but we could make a reserve claim through the Barrnett formula.

147. At Cabinet on 20 and 21 December, exhibit **MD/061 - INQ000057982** refers, I updated on the COBR meeting that I had attended and reported that there had been an offer of further resources for the devolved governments but there was a need to ascertain whether this was additional or simply the bringing forward of funding already announced.

148. Fortunately, the concerns over potential vaccine inefficacy against the Omicron variant did not materialise and, in January 2022 onwards, the Welsh Government commenced the process of lifting the re-introduced restrictions. On 24 March 2022 the requirement to self-isolate was to be moved from the Regulations and into guidance, exhibit **MD/062 - INQ000058010** refers. The options paper for the meeting at which that was decided highlighted that the move away from legal restrictions reinforced the success of the vaccine programme. This paper is exhibited at **MD/063 - INQ000058006**.

149. At Cabinet on 12 April 2022, exhibit **MD/064 - INQ000130049** refers, Cabinet was advised that in terms of the priority to roll-out the spring booster vaccine to the very vulnerable, such as care home residents, those who were immunosuppressed and people over 75 years old, it was agreed that officials should consider whether this could be extended to all disabled people with learning difficulties.

150. At Cabinet on 23 May 2022, exhibit **MD/065 - INQ000130065** refers, the Chief Medical Officer indicated that infection rates driven by the Omicron variant continued to wane and the high level of vaccination in Wales was limiting the number of people who were experiencing serious direct harm from the virus. As the Inquiry will be aware from my Module 2B statement, on 27 May 2022, I issued a statement confirming that after two years of living with coronavirus regulations, these would expire on 30 May 2022, exhibit **MD/066 - INQ000492865** refers.

151. The Welsh Government prioritised working together with the UK Government and the other Devolved Governments in a common approach to vaccination. Our commitment to following the Joint Committee on Vaccination and Immunisation's advice minimised the risk of differences in approach to eligibility and prioritisation. There was a high degree of synergy across the UK.

152. In Wales, the relevant authorities were our seven Health Boards. We have a planned and unified health system in Wales. Heath Boards were able to calibrate implementation of the national approach with their own localities. For example, Betsi Cadwaladr University Health Board utilised its primary care services to reflect its rural nature.

Vaccination as a Condition of Deployment

153. As I have outlined elsewhere in this statement, our aim in Wales was to create a 'high trust' basis for the actions that the Welsh Government were taking in Wales. Our ability to secure high levels of vaccination take-up was predicated upon that 'high trust' environment. A policy of mandatory vaccination as a condition of deployment is self-evidently a 'low trust' measure. To have adopted such a course of action would have undermined the whole basis of our approach and potentially put at risk the success we had achieved in the vaccination

programme generally which was achieved by working with partners and citizens across Wales.

154. As may be seen from the vaccination rates below, we were consistently above those advised as necessary to protect against outbreaks and so there was no justification to undermine the trust we had built with the Welsh public.

155. As with other decisions relating to the vaccination programme, the decision as to whether vaccination should be a condition of deployment for health and social care staff in Wales was one for the relevant Minister for Health and Social Services. However, as detailed earlier in this statement, I would routinely be copied into advice and briefings related to such issues, with considerations and discussions surrounding these decisions regularly being raised at meetings in which I participated.

156. In late-March 2021, I am aware that a paper submitted to Covid-O suggested that the UK Government had agreed that care home workers in England would be legally required to be vaccinated against Covid-19 in order to retain their current role. Upon becoming aware of the UK Government proposals for mandatory vaccination, the then-Minister for Health and Social Services, Vaughan Gething, and I requested officials to prepare a note on the consultation undertaken by the UK Government in formulating those proposals and the implication of those proposals were they to be introduced in Wales. There was no attempt by the UK Government prior to this to secure a UK-wide agreement on mandatory vaccination as a condition of deployment and we only became aware of this as a result of our engagement with their decision-making generally.

157. This was subsequently prepared jointly by social care officials and the Wales Covid-19 Vaccination Programme Board and was provided to the Minister for Health and Social Services and I under cover of an e-mail briefing sent on 23 April 2021. I exhibit a copy of the briefing and advice note at **MD/67 – INQ000492844** and **MD/68 – INQ000492845**. The briefing confirmed that the UK Department of Health and Social Care had launched a formal consultation on 14 April to obtain views on its proposals and a potential extension of those proposals

to not only cover frontline residential care workers, but also other visitors / employees.

158. We were informed that the Social Care Working Group of SAGE had advised that an uptake rate of 80% in staff and 90% in residents in each care home setting was required to provide a minimum level of protection against outbreaks on a single-dose basis, with the potential for this to reduce after second dose (subject to emergence of new variants). At this time, whilst take-up in England remained generally below those levels, Wales was comparatively higher and above the SAGE recommended minimum levels. Work remained ongoing by Local Health Boards and social care bodies to encourage those remaining to take up the vaccination. Social care employers were being reminded of the need to respect individual choice, alongside undertaking risk assessments and continuing to create a Covid-19-safe workplace by use of PPE, handwashing and other infection control measures separate to the vaccination programme.

159. The accompanying advice note set out the rationale in support of and against implementing a comparable policy change in Wales. It was recognised that any intervention able to reduce risks posed to older residents living in care homes in Wales was one that should be explored in more detail and evidence suggested that those who were vaccinated were less likely to transmit the disease to others. Evidence was emerging from local authorities and social care providers to suggest that some individuals and their family members were specifically requesting vaccinated workers to be involved in the delivery of care packages, which could place additional strain on the sector. Whilst there was little evidence of the likelihood of removal of residents on the basis of non-vaccinated workers, it remained a consideration as a reduction in occupancy could present a risk to the financial sustainability of a care home.

160. It was further recognised that the introduction of a policy of mandatory vaccination could improve uptake amongst vaccine-hesitant workers. It was noted that there was particular hesitance in specific ethnic minority and faith groups, along with more deprived areas. There are high numbers of staff from Black, Asian and Minority Ethnic groups within the social care workforce and, as a low paid occupation, much of the workforce falls within lower socioeconomic groups, which

meant a policy for mandatory vaccination would target many of those who were already identified as vaccine-hesitant.

161. Balanced against the above was the fact that the vaccination take-up in Wales was above the suggested minimum rates in modelling undertaken by SAGE. As at 20 April 2021, 90.1% of care home workers had received a first dose and 76.7% for the second dose, whilst 97.5% of residents had received their first dose and 86.5% their second, which exceeded the minimum thresholds by some considerable way. It was also noted that there were many reasons behind vaccine hesitancy, not all of which were associated with anti-vaccination sentiments, including changing advice on vaccination for certain groups (such as pregnant women and those with allergies), the potential for false-positives on routine testing (thereby delaying the ability to receive a vaccination) and logistical issues.

162. It was noted that the vaccine did not provide 100% protection and regard was had to SAGE advice that there was a risk that mandatory vaccination could increase vaccine complacency in relation to the use of appropriate PPE and infection prevention control measures, particularly at the point where extra vigilance was needed against new variants with poor vaccine efficacy. Further, and given the time post-vaccination to build up immunity, evidence of vaccination did not necessarily mean that a newly vaccinated person presented any less of a risk than one who was unvaccinated.

163. A particularly important consideration against mandatory vaccination was the fragility of the social care workforce. There was little evidence that mandated vaccination would have the desired effect of changing the minds of those who were most reluctant. If non-vaccinated workers were to be dismissed, this would have made it difficult for care homes to main safe staffing levels or even potentially be able to safely operate at all, which could result in home closures, thereby displacing residents. There was also a possibility that staff who refused to be vaccinated would then move into another sector that did not require vaccination (such as domiciliary care) but involved individuals who were only slightly less at risk than those in care homes.

164. In addition, there were issues regarding the limits of the policy of mandatory vaccination for care home workers only. Controlling access to all visitors in care homes (or requiring their vaccination) was not realistic, and the restriction of access to certain visitors could in itself prove problematic. Further, there was no suggestion of mandating vaccination for residents, which resulted in the potential for the SAGE thresholds not to be reached even if the policy were imposed.

165. The advice of officials confirmed that, whilst there were some important arguments for pursuing a similar change of policy in Wales, there were significant logistical and moral challenges that would need to be overcome to ensure such a policy provided the desired protection. Whilst difficulty of implementation was not a barrier to the introduction of the policy, the potential to cause undesirable consequences needed to be weighed against the potential success. Having considered the impact of staff absences during the earlier stages of the pandemic on the sector, the significant risk posed to operational stability and resilience of the care home sector if there were to be losses of up to 10% of the workforce was a vital consideration and one which was compounded by pre-existing difficulties with recruitment and staff retention.

166. Balancing the primary Covid-19 risk to care home residents, against the secondary wellbeing risks from visitor restrictions was important, particularly in light of the limited evidence that the policy would have the desired effect and could also promote complacency in other areas. As Wales' vaccination rates already exceeded the minimum standards set, the advice was that more focused action on areas such as procedural, cultural or service-specific barriers to vaccine would drive better outcomes. Alternate avenues to be pursued included:

a. Increased media coverage of vaccination, with emphasis on hard-to-reach groups and those who were vaccine-hesitant;
b. Additional campaigns on social media channels;
c. Identification of any care homes falling below SAGE minimum thresholds and engagement with those homes to ascertain how to improve take-up;
d. Engagement with faith leaders and community groups to better understand cultural barriers and improve take-up in those communities;

e. Offering a mobile mop-up service to care homes where staff had faced logistical barriers in getting vaccinated.

167. I am aware that, in mid-June 2021, officials became aware through reports that there was to be an announcement the following day by the UK Government for mandatory vaccination of care home staff, with a further consultation likely for extension of that to health care staff generally. This did not change our stance on the issue and our focus remained on the reinforcement of the positive response to vaccination in the social care sector we were already seeing.

168. On 23 June 2021, I received a further briefing paper on the issue of mandatory vaccinations for care home workers and asked for the same to be circulated ahead of a ministerial call the following day. A copy of this briefing is exhibited at **MD/69 – INQ000485797**. This briefing set out the up-to-date evidence on take-up in Wales (which remained significantly above the minimum threshold), by comparison to the other UK nations. It also shared the ethical considerations identified by the Covid-19 Moral and Ethical Advisory Group as part of its work on this issue, and detailed stakeholder views from various bodies. It then went on to detail the impact of such a policy, both upon the sector and for the vaccination programme generally, the alternative options to mandatory vaccination, and the legal and financial considerations. The recommendation continued to be that, as a result of the high uptake of vaccination by staff in older adult care homes, mandatory vaccination was not imperative at that time.

169. This paper was discussed at the ministerial call held on 24 June when the consensus of Ministers was to agree to the recommendations in the briefing. I also asked for some work to be undertaken to ascertain whether there could be a requirement for the publication of figures of people vaccinated on a global basis (not to identify individuals) by care homes on their websites, with regular updates provided. I exhibit a note of the outcome of this meeting at **MD/70 – INQ000485799**.

170. The requested advice was provided on 29 June 2021, to which exhibit **MD/71 – INQ000485939** refers. In light of the various logistical issues with such publication, the generally high level of uptake of vaccination among staff and the

continued need to provide individualised targeted support for any care homes with a lower uptake, the advice was that compulsory publication of vaccination rates at the level of individual care home services may not be considered proportionate.

171. I accepted this advice and confirmed that I did not wish to pursue mandatory publication at that time. However, I invited officials to consider means by which providers could be encouraged to publish this information on a voluntary basis to residents and potential residents to continue to drive the importance of maintaining the highest rates of staff vaccination. Officials thereafter met with a representative from Care Forum Wales and with Data Cymru to discuss the issue and it was confirmed that staff vaccination rates could be requested for inclusion within the information provided by care homes on the existing Dewis website and the CareHome.Wales website that was in development, the former of which was utilised by approximately 85% of care homes already. Confirmation of this was provided to me in further advice dated 7 July 2021, exhibited at **MD/72 – INQ000485807**. Following this advice, I requested pursuit of voluntary publication of this care information by care homes, which had been confirmed by officials to not constitute a significant extra task.

172. In the meantime, I am aware that then-Minister for Health and Social Services, Eluned Morgan, had issued a Written Statement on 29 June 2021 confirming the Welsh Government position, as discussed in the aforementioned ministerial call. This statement confirmed that vaccination uptake by care home workers had been high and that, whilst the situation continued to be monitored with the NHS and care home sector, there were no plans to require mandatory vaccination in Wales at that time. A copy of that Written Statement is exhibited at **MD/73 – INQ000490080**.

173. Further, and on 9 July 2021, the Welsh Government published guidance entitled '*Covid-19 vaccinations; guidance for employers*', which sought to assist employers in Wales to deal with the implications of vaccinations on their workforce. A copy of this guidance is exhibited at **MD/74 – INQ000082149**. This confirmed that vaccination was not a mandatory requirement. Importantly, and whilst work on the encouragement of vaccination continued, the guidance also emphasised that other methods of infection prevention control remained important and that

employers needed to comply with existing legislation to avoid discriminating against unvaccinated staff.

174. In a paper received ahead of the Cabinet meeting held on 13 September 2021, officials advised that 91% of staff in older adult care homes in Wales had been double vaccinated by that point, with separate advice to follow in recognition of the consultation on compulsory vaccination of health and care staff in England. The separate advice referred to is attached as exhibit at **MD/75 – INQ000057876.**

175. On 28 September 2021, I received further advice on the voluntary publication of staff vaccination data by care homes, a copy of which is exhibited at **MD/76 – INQ000507388**. This confirmed that work by officials with Data Cymru to develop the CareHomes.Wales website continued and, in the interim, the intention was to publish the information on the Dewis service directory, subject to considering the views of various stakeholders with whom officials were engaging.

176. On 9 November 2021, and following its earlier consultation, the UK Government made a further announcement stating that vaccination would be mandatory for all frontline NHS workers in England from 1 April 2022, subject to exemptions for medical reasons and those who don't have face-to-face contact with patients. This was expected to impact an estimated 100,000 NHS England staff who were unvaccinated at that time.

177. Advice on this announcement and its implication for Wales was prepared and which I exhibit at **MD/77 – INQ000485872**. This confirmed that Scotland had not made any proposals to make vaccination compulsory for NHS workers or care home staff, while a public consultation was expected in Northern Ireland. Uptake amongst health and social care staff remained high in Wales with 91% of care home workers and over 95% of health care workers having received both doses of the vaccine and more than two-thirds of the latter group having already received their booster jab. The view remained that, whilst vaccination rates were at such high levels amongst these groups, compulsory measures were not required in Wales. The intention was for officials to continue working closely with health and social care sectors and professional bodies, employers and unions to promote uptake of the vaccine.

178. Insofar as communication and liaison with the UK Government and other Devolved Governments on this issue, to the extent to which it occurred, this generally took place at an official-level or between the respective Health Ministers. I understand the now-Prif Weinidog, Eluned Morgan, has detailed her involvement with this in her statement. Whilst there was much consistency in approach in vaccine-related issues, this was one area where approaches differed between nations as the considerations and justifications were not equal between them.

179. As detailed above, the decision whether to mandate vaccination as a condition of deployment was finely balanced. We needed to take into account ethical, legal and logistical considerations and weigh those up against the potential benefits and risks to the sector and the residents and patients for whom it cared in adopting such an approach. One of the key factors in the decision not to mandate vaccination for health and care workers in Wales was the increased uptake rates amongst staff. While the staff vaccination rates remained consistently and substantially above the minimum threshold outlined by SAGE modelling, the balance remained in favour of not requiring mandatory vaccination as a condition of deployment in Wales.

Part D: Public messaging in respect of the Covid-19 vaccines

180. From the outset of the pandemic, I knew it would be essential that the people of Wales had access to clear, timely and consistent information on how to keep themselves and their loved ones safe. I was determined throughout the pandemic that our communications response should speak to the people of Wales in a way that was clear, direct and honest. This approach continued through to the vaccination-specific communications. The people of Wales needed access to clear and authoritative information about the vaccines in order that they could understand the issues and make informed decisions to come forward and have their vaccination.

181. The vaccination public messaging work was led by the Communications Team of the Health and Social Services Group and the day-to-day decision-making responsibilities on matters such as managing the Vaccination Programme communications fell within the remit of the Covid-19 Vaccination

Programme Development Group. The corporate vaccine statement of the Welsh Government for this module sets out the approach taken and the work carried in respect of vaccine-related public messaging in full and I refer the Inquiry to that statement.

182. The Covid-19 Vaccination Strategy for Wales and Vaccine Equity Strategy for Wales (and their updated successors) also included communication and engagement strategies. These focused upon the development and use of trusted voices which I explain further below and engagement groups to lead engagement with communities in order to empower understanding within those communities of the benefits of vaccination and to support and motivate others to be vaccinated.

183. Officials led on the choreography of four nations messaging, with any Ministerial discussions upon such communications taking place via the respective Health Ministers of the four nations. I was not involved in these discussions, although I understand details of these have been set out in the statements of the respective Ministers for Health and Social Services.

184. One of the key aspects of my involvement with public messaging was via the televised press conferences where I, my Ministerial colleagues and clinical experts spoke directly to people in Wales to provide the latest information about the spread of the virus, reinforce our public health messaging, and demonstrate that we were open to scrutiny and challenge. Once the vaccination programme commenced, these press conferences were also used to provide updates on the number of people who had been vaccinated and to encourage those not yet vaccinated to come forward, with a particular emphasis upon the repeated messaging that it was never too late to do so. By way of example, I exhibit my script and accompanying slides for the press conference on 7 June 2021 at **MD/078 - INQ000090692** and **MD/079 - INQ000090693**, and those for 17 September 2021 at **MD/080 - INQ000090707** and **MD/081 - INQ000090710**.

185. I always sought to communicate in a way that was straightforward and open with the Welsh public, particularly regarding decisions that were finely balanced. Insofar as vaccination communications were concerned, my voice

(and those of my fellow Ministers) was routinely accompanied by trusted clinical and medical voices ranging from the Chief Medical Officer (Wales), Public Health Wales, public health experts and Muslim Doctors Cymru. Public messaging also signposted the relevant clinical advice on vaccinations (such as the Joint Committee on Vaccination and Immunisation), thereby clearly setting out the risks and benefits of being vaccinated, particularly for different cohorts. Vaccine safety (to which I return later in this statement) was a particular feature because, as stated above, we wanted people to feel that they had sufficient information to make an informed choice.

186. To the extent to which I am asked for my view on the effectiveness of the public messaging strategy and the sufficiency of the methods for assessing and monitoring such, whilst I am aware that such assessments were taking place at an official level, these are not matters that fell within the scope of my day-to-day Ministerial responsibilities. Where relevant, such matters would have been brought to my attention in briefings prepared for my attention. For example, I was routinely made aware of the results of Public Health Wales' monitoring of public attitudes and the Ipsos MORI surveys undertaken on behalf of the Welsh Government.

187. When considering effectiveness generally, I consider that there were essentially three different categories of people that public messaging reached: (i) those highly receptive to the vaccination programme, (ii) those who were hesitant but open to considering matters, and (iii) those who were anti-vaccination and beyond the reach of any messaging.

188. In my view, those falling within category (i) were highly receptive to the Welsh Government's messaging. We are fortunate in Wales to have a population who are very largely community minded. People engaged with the vaccination process not just because it was the right thing to do for themselves, but also because they recognised that it would put Wales in a better place communally. I recall, for example, an experience in January 2021 when I visited Skewen. The primary purpose of my visit was related to an incident that had occurred where a mine shaft in the area had blown out during a storm and caused significant flooding the village. Whilst there, I passed a vaccination

centre and, despite the inclement weather and recent events, there were significant proportions of the over-75 population attending to have their vaccinations. It was not an easy day for them to get to the centre and, upon speaking with them, it transpired that this was the first time many of them had been outside for several weeks. In my view, this was a real-life example of how the Welsh Government's public messaging was being received by the Welsh public and of how their receptiveness to that messaging was fundamental to the success of the vaccination programme.

189. Those falling within category (iii) were much smaller in number but often could be quite loud in public and social media spaces. Misinformation was a very real risk and we were very aware of that. I will return to the approach taken in respect of these (and misinformation and disinformation generally) towards the end of this section.

Vaccine Hesitancy

190. Considerable efforts were made to target those 'vaccine hesitant' people falling within category (ii). As set out above, we sought to focus our efforts upon providing as much authoritative evidence for people as possible. We always wanted to advocate a high-trust, persuasive approach rather than pressuring or forcing people to have the vaccine, which would represent lower levels of trust. Those identified as 'vaccine hesitant' would not necessarily be receptive to traditional channels of government communication and so steps were taken to consider alternative approaches.

191. In pursuing these alternative approaches, we sought to specifically target vaccine inequity. As set out above, I had set up the Black, Asian and Minority Ethnic Covid-19 Advisory Group in 2020 to investigate the underlying reasons for the growing evidence that Covid-19 had a disproportionate impact on people with such backgrounds. This Group published a Risk Assessment tool for use by people with Black, Asian or Minority Ethnic backgrounds as well as anyone with vulnerabilities. Professor Ogbonna had also led a Socio-Economic subgroup which published a report in June 2020. I exhibit the advice under which I was provided with a copy of this report at **MD/082 - INQ000144915**.

192. The report made many recommendations which have featured significantly in my earlier statements to the Inquiry. However, for current purposes, it also reflected the importance of appointing personnel on the ground who had trusted relationships, existing knowledge of the services and who could mobilise action by individuals and communities as well as advise policymakers and health service providers.

193. In early-October 2020, by decision made by then-Minister for Health and Social Services Vaughan Gething, this was carried forward by the appointment of dedicated Black, Asian and Minority Ethnic outreach workers in each Health Board to support the Test, Trace and Protect programme. As detailed in the Covid-19 Vaccination Equity Strategy for Wales, exhibited at **MD/083 - INQ000182538**, this funding continued to be made available for the appointment of outreach and engagement workers within each Health Board to support with engagement and advocacy relating to the vaccination programme. At that time, grant funding of over £2.5m had been awarded to 27 organisations through the Welsh Government's Coronavirus Recovery Grant for Volunteering, facilitated by the Wales Council for Voluntary Action (WCVA) to help support and sustain volunteering and community action during recovery from the pandemic.

194. Officials would meet with the 'community champions' or mentors to check in and get feedback on the process. Community champions were faith leaders, community leaders, sports and cultural figures and were often respected figures within the community, this term was interchangeably used with the term "trusted voices" who were members of Public Health Wales, health professionals to include frontline NHS workers (doctors to include Muslim Doctors Cymru, nurses, GPs), life sciences and health academics, together with peers of eligible and / or vaccine hesitant groups in a range of communities. Again, they were trusted members of the community and would be regarded as mentors to those within the community and were engaged in order to increase confidence and trust within the vaccine programme. I exhibit at **MD/084 - INQ000492812,** an update I received in February 2021 confirming that the feedback at this stage was encouraging with mentors expressing very positive initial engagement with policy leads and a keenness to continue supporting the development of goals and actions as much as possible. The document highlights that, at that time, as part

of the Keep Wales Safe – Covid -19 Public Information Campaign, 36 different community and faith organisations were engaged in the process to directly address the concerns of the communities represented and to tackle any circulating misinformation.

195. An update provided in March, exhibited at **MD/085 - INQ000492890**, confirmed that officials were also working with Local Authority Outreach workers to engage with Gypsy, Roma and Traveller communities, utilising their existing connections within those communities.

196. On 8 June 2021, Minister for Health and Social Services, Eluned Morgan, published a Covid-19 Vaccination Strategy Update in which it was confirmed that a specific strand of the Welsh Government's action plan was to increase confidence and trust, including by way of taking such steps as using trusted voices and community champions to promote key messages including the new community and engagement officers that had been placed in each Health Board to work with local communities to support the vaccination programme, as well as making sure that migrant communities knew that personal data was not being shared outside of the vaccination programme.

197. This Update emphasised the 'No one left behind' principle that the Welsh Government was operating under and confirmed the set-up of two committees / groups specifically created to target the issue of uptake and to put action in place: the Vaccine Equity Committee and the DNA (did not attend) working group. I am aware that these groups undertook a lot of work in this space. I was not directly involved in that work but was kept up to date with the same by way of briefings from Gillian Richardson and others involved. I exhibit at **MD/086 - INQ000492853** an example of an equity briefing I received on 24 May 2021. The Minister for Health and Social Services and I would also regularly receive updates on vaccine equity and the work being done to support this at the weekly vaccine update meetings to which reference has been made. I exhibit at **MD/087 - INQ000485801** an example of one such update provided to us on 22 June 2021. The set-up and work being undertaken by these groups has also been detailed in the corporate vaccine statement and in the personal statement of Gillian Richardson and I refer the Inquiry to these.

198. Alongside the use of these 'community champions', the Welsh Government also held events such as an online vaccination roundtable on 9 February 2021 which was a Q&A-style event permitting representatives from multi-cultural faith, community and business organisations from across Wales to ask questions and hear from a panel of experts that included representatives from the Medicines and Healthcare products Regulatory Agency, NHS bodies, Public Health Wales and a frontline healthcare professional. This was attended by over 140 individuals representing more than 50 organisations and insight gained was able to be reviewed to determine future content needs. Efforts were also made to directly answer questions from the public by the use of Facebook Live sessions that were undertaken by Ministers and, indeed, by constituency members.

199. The Welsh Government supported the Black, Asian and Minority Ethnic Helpline, which aimed to offer an accessible and multilingual first port of call. This Helpline was funded by the Welsh Government and run by the Ethnic Minorities and Youth Support Team Wales (EYST), in partnership with the Wales Council for Voluntary Action (WCVA) and various other organisations. Further support was provided by increased Welsh Government press and social media activity to promote its availability.

200. The accessibility and inclusivity of communications was considered at length by the Inquiry in Module 2B. I have already exhibited a copy of my Module 2B statement above. As indicated in that statement, and in the first instance, Welsh and English are both official languages in Wales and therefore our communications and messaging were bilingual throughout the pandemic. This was not simply a question of translating English into Welsh, but also providing tailored messages that resonated with communities right across Wales. This meant people were able to receive public health messages in the language of their choice and with a tone that reflected public sentiment as closely as possible across different stages of the pandemic.

201. The Communications Directorate of the Welsh Government also provided a substantive statement to the Inquiry in Module 2B which detailed the work

undertaken to ensure that communications were provided in many different languages and accessibility formats, including Braille, Easy Read, large print and British Sign Language. I exhibit a copy of this statement at **MD/088 - INQ000340123**.

202. I was kept updated of the work being undertaken in this area via the monthly Black, Asian and Minority Ethnic Advisory Group Communications updates. I exhibit the update received for January 2021 at **MD/089 - INQ000388308**, in which I was informed that recent work had been undertaken in conjunction with our contracted agency, MMC (Multicultural Marketing Consultancy) to ensure the 'Keep Wales Safe' campaign was reaching and engaging with Black, Asian and Minority Ethnic communities in Wales. Recent activity at that time had included multilingual street teams in Cardiff who visited community spaces / businesses, to meet with people and hand out materials. Over two days (with activity then having to be paused due to the re-introduction of restrictions), the team had visited 126 community spaces / businesses, had around 1,500 interactions and handed out over 1,800 printed materials.

203. I am asked whether public messaging was adapted appropriately and in a timely manner to deal with evolving advice on particular groups, such as pregnant / breastfeeding women, children and specific age groups. The best assessment of those matters would be in the take-up rates themselves. If large numbers of those specific groups did not come forward for vaccination, that would have suggested that the messaging strategies were not working as effectively as we would have wished. As indicated elsewhere, the extension of the vaccination programme to these groups occurred in line with the Joint Committee on Vaccination and Immunisation's advice, with public messaging generally announced on a four-nations basis.

204. In Wales, we supplemented that work by messaging specifically directed at groups where amplified information might increase take-up rates. Those efforts included Ministers, officials, public health clinicians and individuals with particular standing in relevant communities. This concerted and coordinated effort was especially helpful as concerns evolved over the vaccination period. I understand that Eluned Morgan has referred to some examples of this in her

statement, such as her engagement with the Royal College of Midwives to encourage the take-up of vaccinations amongst pregnant women.

205. I recall specifically doing a series of videos with prominent people immediately as they had been vaccinated, to publicise take up. These were videos made bilingually in Welsh and English with prominent people such as Gareth Edwards CBE and Beti George.

Misinformation and disinformation

206. Returning to the issue of misinformation and disinformation, the Welsh Government's communications teams undertook social media listening and tracking of those issues. Whilst there was some opportunity to target some of that misinformation with clinical advice and evidence, it was also important not to provide the more egregious misinformation with any unnecessary airtime. People falling within this category are largely beyond the reach of any Government messaging. Instead, our public messaging was always focused upon the positive and proactive steps to be taken, rather than trying to counter the negative narratives. To those falling with category (iii) above, any message from Government is often taken as 'proof' of a conspiracy and I did not want to feed into such misinformation in any messaging in which I was involved.

207. Other than references to these matters in CDL calls, I had no involvement with liaising with relevant decision-makers in the other nations regarding the countering of vaccine disinformation / misinformation. This was undertaken at an official level and I understand it involved intelligence sharing and insights from experts / specialists in the area. Consistency of public messaging was particularly important in the area of misinformation and the four nations engagement being undertaken by officials enabled the Welsh Government to become aware of any issues occurring in the other nations before they reached Wales and vice versa. I am not aware of any further actions which could have added to the effectiveness of our efforts to combat misinformation. However, in an age of artificial intelligence, this is a matter which any Government would wish to remain under review.

208. I refer the Inquiry to the detail contained in the corporate vaccine statement in this module for further evidence as to the ways in which the Welsh Government responded to such misinformation and disinformation and the four nations engagement taking place.

Part E: Barriers to vaccine uptake

209. On a broad basis, levels of public confidence and trust in the Welsh Government were generally high during the pandemic, particularly by comparison to our UK Government counterparts. I have previously set out in my Module 2B statement the results of Ipsos MORI periodical surveys that were being undertaken which demonstrated that from May 2020 onwards, as restrictions were being eased following the first lockdown, trust in the Welsh Government had increased to around 80% (as compared to 40% for the UK Government).

210. However, despite this general engagement, we were aware that there were small groups who were vulnerable to distrust in government and / or to persuasion by misinformation and disinformation generally. Where this is the case in any aspect, there are limits as to what the Government and those who are seen as part of it can do. Attempts to persuade such groups run the risk of making the situation worse. When faced with circumstances involving groups of people or communities who had mistrust towards the vaccine or the Government generally, we had to consider other techniques of reaching into these groups and communities and I refer the Inquiry to examples of those techniques outlined in the preceding section.

211. Insofar as steps I personally took to encourage vaccine uptake, as detailed above, the successful deployment of the vaccination programme and the fact that vaccination was the key to unlocking Wales was an important message that I sought to emphasise in press conferences and other media appearances. Whenever I or my fellow Ministers would attend to be vaccinated, this would be publicised so as to demonstrate that we were acting upon our own message to get vaccinated. I also undertook visits to vaccination centres and held discussions with the staff involved in delivering the vaccine.

212. In a vaccination-context, it was recognised that Ministerial voices cannot replace those of clinicians and so it was particularly important to know when to step back and permit those with medically authoritative voices, such as the Chief Medical Officer for Wales, who would routinely be involved with the press conferences, to deliver messages and promote trust in the vaccine.

213. Further, and whilst trusted voices and community champions took the lead in those communities that were less receptive to Government messaging, it remained important for the Welsh Government to continue to work closely with those trusted voices within the communities. For example, I visited local mosques in the company of members of Muslim Doctors Cymru. Muslim Doctors Cymru were founded by a group of Cardiff doctors in January 2021 who, having noticed relatively high levels of concern among ethnic minority communities towards the vaccines, sought specifically to combat misinformation on the Covid-19 vaccines among Ethnic Minority communities in Wales and beyond. They recruited volunteer health care professionals, faith leaders, charities and local businesses to develop a community-based campaign to address the issues and provide education and health promotion aimed at Ethnic Minority communities.

214. Organisations like Muslim Doctors Cymru permitted different communities to receive information in their own language from a trusted community voice, which provided credibility to the messaging and the vaccination programme. By undertaking community visits with members of Muslim Doctors Cymru, such as those to the local mosques, I hoped to reinforce that credibility and provide confidence in the ability to trust Government messaging and, thus, the vaccination programme itself. It was my impression during occasions such as these visits that any mistrust and / or hesitancy, came from a background of anxiety, rather than hostility.

215. The issue of how vaccine delivery and barriers to take up were addressed in Wales and the response of the Welsh Government is explained in detail in the corporate vaccines witness statement in this module, to which I refer the Inquiry.

216. One of the key bodies involved in this work was the Vaccine Equity Committee whose purpose was to provide advice to the Wales Covid-19

Vaccination Programme Board on how to ensure all people in Wales who were eligible for Covid-19 vaccination had fair access and fair opportunity to receive their vaccination by addressing barriers that disproportionately affected under-served population groups. As per the Vaccine Equity Strategy (exhibited at **MD/083 - INQ000182538** above), this was to be achieved by coordinated and concerted action following a community led approach to allow local concerns to be raised and specific barriers acknowledged and addressed through tailored support.

217. As already set out above, I would receive regular updates on the work of the Committee by way of briefings from Gillian Richardson and others involved at the weekly vaccine update meetings. I have exhibited such updates throughout this statement, where relevant.

218. Given the longstanding concerns of successive Welsh Governments to address health inequalities, the likelihood of differential take-up of vaccination was always part of our understanding and therefore our response. We were able to do so by drawing on an extensive and successful experience of promoting vaccination amongst hesitant groups in the deployment of other vaccines, such as MMR and HPV. As noted earlier, I am not aware of any other measures or wider repertoire of actions which could have been deployed in this regard. I was and remain content that the Welsh Government had access to suitably expert advice and that our efforts to promote vaccine take-up amongst under-served groups was not hampered by any lack of access to such advice.

Part F: Vaccine certification

219. During the relevant period, the implementation of a vaccine certification / passport scheme in Wales was considered in both an international and domestic context.

220. I have been asked to specifically provide a chronology of the decision-making process in respect of the vaccine certification scheme. However, I think it important to state that the length of this section should not be interpreted as the

scheme having an impact on the public which an explanation of this length might imply. I have included the detail below to address the questions raised.

International Certification

221. The topic of certification of Covid-19 vaccination status initially arose in the context of international travel.

222. During a CDL call on 28 April 2021, focus turned to certification and international travel. At this time, a number of countries had signalled an intention to require confirmation of Covid-19 vaccination status as part of their entry requirements. Attendees on the call were advised that the UK Government was looking at the expansion of international travel and on the digital development by NHSX of their app for international travel, similar to the "green pass" Covid-19 certificate scheme recently introduced in Israel.

223. I was particularly concerned about how Israel had dealt with ethical and security issues in the introduction of their scheme and raised this with the Chancellor. I also noted that vaccine take-up was high in Wales so any suggestion that the implementation of such a scheme was necessary to increase this was not a problem relevant to Wales. I expressed my general concerns about the threats posed by increasing international travel. Finally, I was particularly keen to emphasise that, on the timing of the development of the NHSX app, I did not consider it acceptable to have an England-only digital solution, especially in the light of equity concerns rehearsed earlier in this statement. I expressed my hopes that matters would not move ahead until it was operational on a wider basis. I exhibit a note of this call at **MD/090 – INQ000216583**.

224. On 11 May 2021, I was advised (alongside the then Minister for Health and Social Services, Vaughan Gething) that Welsh Government officials had been working closely with UK Government counterparts on the digital and non-digital delivery options for Covid-19-status certificates to support outbound international travel. The UK Government had confirmed that it would utilise its existing NHS app for use by residents in England in which those wishing to travel

could house a vaccination certificate to meet entry requirements set by other countries. It was intended that this service would be available from 17 May 2021 although, at this stage, the UK Government system was to be available for residents of England only. This was unfortunate given my earlier-raised concerns designed to avoid exactly such an outcome.

225. The then Minister for Health and Social Services and I were asked to (and duly did) agree that officials should continue to aim to operate a joint England and Wales certification system once digital services could be aligned, with an interim system referred to as Welsh Vaccination Certification Services, to be delivered by Swansea Council contact tracing team, until that alignment could be arranged. I exhibit this advice at **MD/091 – INQ000176839**.

226. On 24 May 2021, the Minister for Health and Social Services Eluned Morgan, made a Written Statement (exhibited at **MD/092 – INQ000492850**) announcing the availability of this temporary system to enable people in Wales to obtain a letter demonstrating their vaccination record. At the time, the Welsh Government's position remained that international travel should only be undertaken for essential journeys, and this was emphasised.

227. Officials in the Welsh Government continued to work with the UK Government to put in place and England and Wales digital solution.

228. On 23 June 2021, I was copied into advice for the Minister for Health and Social Services, which sought agreement that online access to vaccination status certificates should be made available once data flows were undertaken, accepted and tested. At this point, the NHSX App was still not available for Wales so the digital solution agreed with NHS England had been for access via webpages, which a Welsh citizen could log in to and confirm their vaccination status using their NHS number. This advice also sought agreement that the existing paper-based certificate service should continue for those individuals who would need to make a telephone request for vaccine status to be confirmed, until further work was undertaken on the costs of transferring this service to 119. A copy of the advice is exhibited at **MD/093 – INQ000136891**.

229. The introduction of the digital NHS Covid-19 passes (known as the 'NHS Covid Pass') in Wales occurred on 25 June 2021 and was announced on behalf of the Welsh Government by the Minister for Health and Social Services in a Written Statement. The Welsh Government's advice at that time remained that only essential overseas travel should be undertaken.

230. The NHS Covid Pass system in Wales for international travel remained in place until 4 December 2023. The existing non-digital service also remained an option for those who were unable to access the digital pass system until 31 October 2023, at which time the Minister for Health and Social Services took the decision not to renew the Welsh Vaccination Certification Service contract provided by Swansea Council. Whilst the online access workaround referenced above was available to people living in Wales, the NHS Covid App was never reconfigured to enable access to Welsh citizens.

Domestic Certification

231. Insofar as the use of a Covid-19 vaccination certificate / passport in a domestic context is concerned, the decision to introduce such a scheme in Wales was finely balanced. Restricting the movement of individuals carried with it ethical considerations that were always at the forefront of our minds in Wales.

232. Particular caution was required to ensure that the certificates did not risk marginalising certain communities, which meant testing was an important part of the considerations alongside vaccination status. There was also a need to consider exemptions for children and those with certain medical conditions that rendered vaccination unsuitable or unavailable to them. At the time that these considerations were being undertaken, it was also clear that other measures (such as social distancing) were already proven to reduce transmission and there were concerns that the use of certificates could even be counter-productive if they provided a false sense of security or negatively impacted behaviour. That said, it was recognised that there would be significant cross-border issues if England implemented a scheme of this nature and Wales did not.

233. The issue of Covid-19-status certification was first mentioned in a CDL call on 22 February 2021 in relation to the UK Government's considerations as to how England would reach the final stage of removing restrictions post-21 June 2021. A note of this call was exhibited earlier at **MD/036 – INQ000256892**.

234. It was thereafter discussed further and in greater detail at a CDL call on 14 April 2021, to which **MD/094 – INQ000495971** refers. At that stage, the UK Government indicated that it had made no decisions on the issue; there was potential for deployment of certificates in domestic settings, but more work was needed to inform a decision. I outlined my views to those on the call, confirming that I would need to be persuaded of its introduction. I had concerns at that time that it risked being an expensive, ineffective and short-lived exercise, fraught with ethical and practical issues. I indicated that the Welsh Government was more likely to be amenable to its use in situations where people were choosing to attend at a venue, rather than where they needed to. I also emphasised that any system had to observe Welsh language obligations from the outset and raised questions about the interplay between vaccine hesitancy in younger age groups and the venues at which certification may be applied.

235. The lead official from Cabinet Office agreed to share findings from the call for evidence and, in response to my query on hesitancy, outlined that Israel had seen a 22% uplift in vaccine appointments after the announcement of their scheme. It was accepted that the timing of introduction would need careful planning given the timing of younger people being vaccinated. At that stage, the UK Government signalled its intention to announce in May for introduction on 21 June at step 4 of their roadmap.

236. On 18 May 2021, I received a briefing note, exhibited at **MD/095 – INQ000387190** in which I was advised that the UK Government had formally confirmed that it was considering introducing Covid-19-vaccination status certificates for domestic use from 21 June 2021. Whilst confirmation of specific detail remained outstanding, it was understood that the proposal for the use of certification was intended to apply in settings like large sports stadiums, music festivals, large business conferences and large nightclubs. It was expected that the terms of the scheme would provide that 'Covid-status' could be acquired

either through vaccination or testing, with a separate exemption route, although it was intended that these health exemptions would be limited. The note acknowledged that there were wider economic and equalities issues to be considered in deciding whether to introduce such a system to Wales.

237. On 26 May 2021, I received a further paper setting out the various options available to the Welsh Government on vaccination status certificates for domestic use, a copy of which I exhibit at **MD/096 – INQ000353228**. It was noted that the UK Government continued to lead the review on the use of these and that the outcome of this remained awaited. The options available to the Welsh Government at this stage were:

a. To adopt the same policy as England;
b. To confirm that Wales would not use the English system of Covid-19-status certificates but would design its own policy based on clinical evidence;
c. To confirm that Wales would not use Covid-19-status certificates and place the onus on the system in England to produce certificates for people attending from other parts of the UK;
d. To delay the introduction of any Covid-19-status certificate scheme until everyone had been offered a vaccine.

238. At that stage, there were a number of concerns about the introduction of the Covid-19 vaccine certification system proposed by the UK Government. These included ongoing uncertainties as to the efficacy of the vaccination (particularly in light of the continuous emergence of new variants of concern), the reliability of LFD tests given their self-reporting status, the lack of scientific evidence to support the thresholds proposed by the UK Government, the potential for such a scheme to increase risky behaviour and provide a false sense of security and the extent of vaccine coverage meaning that a significant percentage of the population were not fully vaccinated at that time.

239. On a wider basis, there were also concerns about the impact of such a scheme generally on equalities and human rights issues, along with economic

considerations that could see Welsh businesses at a disadvantage should English businesses be permitted to open at full capacity with a scheme in place.

240. Having received a note following the meeting, I am aware that the Minister for Health and Social Services, Eluned Morgan, raised some of these concerns in a CDL call she attended on that same date. Such concerns included the risk of human rights challenges, clinical standards and the timing of a digital solution in Wales. I exhibit a copy of the e-mail note received at **MD/097 – INQ000216584**.

241. On 9 June 2021, at a CDL call, the Chancellor of the Duchy of Lancaster outlined that UK Government was intending to make domestic certification usage voluntary, such as in sporting and entertainment venues. It was confirmed that officials were working with the Welsh Government on the use of the app and a non-digital solution. The situation was to be kept under review by officials in UK Government until the 21 June review date, with engagement with the other nations upon this over the course of the weekend.

242. I expressed a view at this meeting that I considered voluntary use and two doses to be the right approach. I also raised concerns that no advance notice of the use of certificates at Wembley (as detailed in the next paragraph) had been provided as, whilst work could be undertaken to provide certificates in Wales, the process was taking about 10 days. This meant that the timing of the App was critical and extra effort was required to deliver it by 21 June 2021. UK Government officials responded to confirm that they would consider what more could be done on communications or to prove double vaccination status, but that the current timeline for delivering the App was end-July. A note of this call was exhibited earlier at **MD/047 – INQ000216588**.

243. On 10 June 2021, the Minister for Health and Social Services and I were formally briefed on matters arising out of the then-forthcoming Euro 2020 football matches being held in England at Wembley Stadium. In line with the information provided in the CDL call the previous day, Welsh Government officials had been contacted by Wembley Stadium who informed them that the UK Government had asked it to trial the functionality of the NHS app for domestic certification at the

matches. Whilst it was a matter for individual venues what evidence they accepted as proof of vaccine, the proposed entry criteria for Welsh attendees by the UK Government was either a copy of the approved certificate being used for outbound international travel or a negative lateral flow test within 48 hours of the start of the match and Wembley Stadium intended to adopt this approach.

244. As outlined above, at that time, the interim non-digital system remained in place in Wales for international certificates. Applications for certifications could take up to ten days from submission of a request. Further, it was recognised that by agreeing to process applications for certificates to attend a domestic event, this could be suggestive of the Welsh Government agreeing to the concept of domestic certification. However, a refusal to participate in the trial and / or agree to issue certificates for the purpose of attendance would potentially attract criticism from those who had been fully vaccinated. Concerns were that they could consider they were being treated unfairly by comparison to residents of England in their ability to attend matches, or alternatively, would be encouraged to falsely claim international travel in any application.

245. Given the timeline for production of the certificates, it was unlikely that any certificates would have been available prior to the knockout phase (due to take place between 26 June and 11 July 2021). However, it was agreed by both the Minister for Health and Social Services and I that we would confirm that any applications for paper certificates would be processed. It was envisaged that, by the time of the knockout stages, the digital system would be operational. As set out above, the digital NHS Covid Pass system for international use was implemented on 26 June 2021. I exhibit the briefing note and my agreement to the same at **MD/098 – INQ000492855.**

246. The issue of domestic vaccine certification continued to be a relevant issue in the CDL calls throughout June and July 2021. During a call held on 30 June 2021, UK Government officials indicated that, whilst there had been no final Ministerial decision, the direction of travel was that companies and organisations would be able to use domestic certification on a voluntary basis from an agreed date if they considered it would help them attract customers wanting

reassurance. Use was intended to be either through the App or a non-digital solution, with certificates being issued to people with two doses after 14 days, on the basis of a negative PCR / LFD test (home administered) within 48 hours, or on the basis of natural immunity up to 180 days after self-isolation. It was reported that UK Ministers were keen to explore a supervised model for administering lateral flow tests but that there was insufficient capacity.

247. In response, I made clear that Welsh citizens still did not have access to the App in the same way and that it was not available in Welsh. I requested further discussions on voluntary use, particularly given the fraud risks around a paper-based system. I was pleased that the UK Government had reverted to two vaccine doses but was very concerned about the integrity of the system when people could carry out unsupervised testing. A note of this call is exhibited at **MD/099 – INQ000216590**.

248. At Cabinet on 12 July 2021, exhibit earlier at **MD/051 – INQ000129973** refers, the domestic certification was discussed. It was confirmed at that meeting that there were no plans to mandate its use as a form of entry certification to premises or venues, but it was suggested that its use by certain establishments, such as nightclubs, might encourage more young people to take up the vaccine.

249. On 19 July 2021, the UK Government had made an announcement without notice to the Devolved Governments around mandatory vaccine certification for nightclubs and other crowded venues by the end of September. During the CDL call on 21 July 2021, concerns were raised about the lack of engagement preventing a four nations approach on such matters, which needed to improve. It was confirmed that neither the Welsh Government nor the Scottish Government had made a decision on the use of vaccine certification as there remained potential issues relating to equity, ethics, data flow, Welsh language and whether such an approach could be seen as coercive or undermining to the consensual approach to vaccination to date. Emphasis was placed upon the need to work through details such as exemptions and definitions on a four-nation basis. This was accepted by the Chancellor of the Duchy of Lancaster who made a firm commitment to share the working details on vaccine certification to enable proper challenge and collaboration across the four nations. This meeting

was attended by the Minister for Health and Social Services, although I received a note of the minutes following, which I exhibit at **MD/100 – INQ000256898**.

250. In July 2021, the Coronavirus Control Plan was further updated to Coronavirus Control Plan: Alert Level Zero, a copy of which is exhibited at **MD/101 – INQ000066070**. This confirmed that, whilst there were no plans to mandate the use of domestic vaccine certification in Wales at that time, the infrastructure had been developed (via the NHS Covid Pass system) and the Welsh Government would make the Covid Pass available for wider use should businesses and individuals choose to use the system.

251. The issue of vaccine certification was considered in Cabinet on 2 August 2021 where it was discussed whether these should, as was then intended in England, become mandatory for entry into nightclubs and other large venues from the end of September. Given that one of the main reasons for this decision in England was to encourage take-up of the vaccine in the younger population, it was determined that this was not a justifiable reason in Wales where the take-up rates were higher. At this stage, it was concluded that Wales should not adopt such a scheme, although it was noted that businesses could decide to implement such a requirement as one of the reasonable measures within their risk assessments. Cabinet minutes of this discussion were exhibited earlier at **MD/052 – INQ000057896**.

252. On 23 August 2021, I introduced a draft paper to Cabinet inviting discussion of the then-current position on domestic vaccination certification and the use of a 'Covid pass' for entry into high-risk events and venues, such as nightclubs. Cabinet discussed the potential advantages and disadvantages of mandating a pass for certain scenarios and identified the need to consider the ethical issues involved in its introduction and the proportionality of such a system as a response to the existing risks. At that meeting, it was agreed that officials would explore this issue further in order to enable Cabinet to take an informed decision in due course, once the position in England became clearer. However, it was agreed that it would be signalled at a forthcoming press conference that such a scheme was being considered. Minutes of this Cabinet meeting are exhibited at **MD/102 – INQ000057893**.

253. In the CDL call on 8 September 2021, exhibit **MD/103 – INQ000216591** refers, I confirmed that Cabinet would be focusing on several areas following the Joint Committee on Vaccination and Immunisation's advice, one of which was certification. I sought confirmation that a joint England and Wales digital system would be ready by the end of the month, although none was forthcoming.

254. The issue of mandatory vaccine certification was further considered in Cabinet on 13 and 15 September 2021. At this time, Wales continued to be at Alert Level 0 but community transmission remained high, with vaccine-induced immunity beginning to wane, particularly in the older and frailer members of the community.

255. As part of the Cabinet discussions pertaining to the 21-day review due to take place on 16 September 2021, the introduction of compulsory domestic vaccine certificates for entering high-risk events and venues such as nightclubs was discussed. At this time, the Scottish Government had announced a mandatory certification scheme to be introduced on 1 October 2021, whilst the UK Government had postponed its plans for a similar scheme in England the previous day.

256. On 13 September 2021, Cabinet engaged in a wide-ranging discussion around whether to mandate such a scheme in Wales, with a particular concentration on the legal and ethical issues. Alternative options were considered such as the closure of high-risk venues in response to escalating public health difficulties. However, before Cabinet could take a decision upon this, further advice from officials was requested. Such advice was intended to consider various issues including:

a. the practicalities of operating a Wales-only system;
b. an update on the progress made to enable people who were not able to be vaccinated for medical reasons to attend events without disclosing their medical status;
c. potential alternative protection measures and non-pharmaceutical interventions that could be taken;

d. any evidence that UK Ministers may have considered in deciding to postpone the proposed England system and evidence of the impact of the re-opening of nightclubs on transmission rates.

257. This was provided to Ministers and included a further paper from officials dealing with the queries raised by Ministers at the earlier meeting exhibited at **MD/104 – INQ000129991**, a further paper from the Technical Advisory Cell exhibited at **MD/105 – INQ000129989** and further legal advice on the imposition of vaccine certification exhibited at **MD/106 – INQ000129990**.

258. Cabinet reconvened on 15 September 2021 to consider these further papers. The reasoning behind the UK Government's recent postponement of its proposed scheme was unclear, although it was noted that the introduction of mandatory vaccine-only certification remained part of its 'Plan B' responses in the Winter Plan published on 14 September 2021. However, it was noted that the benefits of introducing certification to align with Scotland and England no longer existed and so the note from officials outlined the advantages and disadvantages of a Wales-only system. The papers suggested a series of options, which ranged from progressing a mandatory scheme for launch on 1 October in line with Scotland, to postponing implementation but continuing development work for a later implementation, to confirming that such a scheme would not be implemented in Wales.

259. Cabinet discussions turned to consider whether the existing NHS Covid Pass could be made compulsory for high-risk venues. As this system was already in use, there would be no need for additional IT functionality. Further, whilst the UK discussions had focused on certification being vaccine-only, use of the existing Covid Pass scheme would enable businesses not only to identify individuals who had been fully vaccinated, but also those who had had a negative test (supervised and unsupervised) in the last 72 hours. It was noted that this would address some of the ethical and equity concerns as it would allow those who had been unable to be vaccinated for medical reasons to take a lateral flow test in advance of attendance. Given that this system was only available digitally, it was acknowledged that there would need to be some consideration of alternative systems to allow individuals to demonstrate eligibility. Accordingly, and whilst

either potential scheme created barriers, those relating to the existing NHS Covid Pass were more easily circumvented.

260. In line with the above discussion, Cabinet agreed that the use of the NHS Covid Pass would be mandated for use in nightclubs, high risk venues and a series of identified events, alongside continuing to publicly emphasise the seriousness of the situation in Wales and the potential need to re-introduce other non-pharmaceutical interventions should the public health situation deteriorate further. Insofar as a mandatory vaccine certification scheme, it was confirmed that this would not be introduced by 1 October. However, Cabinet agreed that this would be revisited should the UK Government introduce such a system for England.

261. The minutes for the Cabinet meetings on 13 and 15 September 2021 are exhibited at **MD/107 – INQ000057743**.

262. On 16 September 2021, and in line with the decision made by Cabinet the previous day, I was provided with advice seeking my agreement to signal that the NHS Covid Pass would be a mandatory condition of entry into a number of designated high-risk venues from 11 October 2021. A copy of this advice is exhibited at **MD/108 – INQ000227527**, which I agreed later that day exhibited at **MD/109 – INQ000492858**.

263. I announced the introduction of this scheme at a press conference and published a Written Statement exhibited at **MD/110 – INQ000023299** on 17 September 2021.

264. On 24 September 2021, I was provided with further advice seeking my agreement to the laying of draft Regulations intended to amend the Health Protection (Coronavirus Restrictions) (No.5) (Wales) Regulations 2020 to make provision for the mandated use of the NHS Covid Pass in Wales as a condition of entry in nightclubs and similar venues, indoor non-seated events of more than 500 people, outdoor non-seated events of over 4,000 people and any setting or event with over 10,000 people attending. A copy of this advice is exhibited at **MD/111 – INQ000145486**, together with confirmation of my agreement on 27 September 2021 to the draft Regulations being laid at **MD/112 – INQ000492859**.

265. On 5 October 2021, the Senedd approved the draft *The Health Protection (Coronavirus Restrictions) (No. 5) (Wales) (Amendment) Regulations 2021 which mandated the use of the NHS Covid pass* with a vote of 28 members in favour and 27 against.

266. There were some further amendments to the draft Regulations prior to their coming into force, including to clarify that persons participating in religious services would be regarded as 'normally seated', as advised upon in advice received on 7 October 2021 exhibited at **MD/113 – INQ000145483**.

267. The amended Health Protection (Coronavirus Restrictions) (No.5) (Wales) Regulations 2020, which mandated the use of the NHS Covid Pass in the venues described above came into force in Wales on 11 October 2021. The announcement is exhibited at **MD/114 – INQ000492868**.

268. On 25 and 28 October 2021, Cabinet returned to the issue of the NHS Covid Pass scheme and considered whether its mandatory use should be extended to other settings. At this time, there had been an increase in the number of cases meaning that there was a need to consider how to strengthen existing mitigations to avoid moving to a Covid Urgent scenario.

269. After considering the proposals contained in the briefing note provided by officials, exhibited at **MD/115 – INQ000057939**, it was agreed that the mandatory use of the pass should not be applied to the wider hospitality industry at present upon the basis that the intention to include larger venues within the scheme if conditions did not improve would be signalled. I duly did so at the press conference held on 29 October 2021, exhibit **MD/116 – INQ000090715** refers. It was also noted that those venues could continue to exercise their own discretion to ask customers to use the Pass as part of their reasonable control measures if they wished.

270. However, given the existence of controlled entry procedures already in place for leisure and entertainment venues, cinemas, theatres and concert halls, it was agreed that the mandatory use of the Pass would be applied to those venues, with an implementation date two weeks later. It was agreed that the other venues listed in the briefing note would not be brought in and the cap on the size of events

requiring a Pass would remain in place (which aligned with the rest of the UK) but was to be kept under review. Minutes of the Cabinet meetings on these dates are exhibited at **MD/117 – INQ000057927** and the advice received on 28 October 2021 to effect the agreed extension by the making of relevant amendments of the Regulations is exhibited at **MD/118 – INQ000176896**. This extension came into effect on 15 November 2021.

271. On 15 November 2021, Cabinet considered the further extension of the NHS Covid Pass scheme in light of the paper received (exhibited at **MD/119 – INQ000130000**) although agreed that there would be no decision made on further extensions pending officials receiving feedback from the sector and clarity upon the plans of the Scottish Government to extend and providing further advice. Minutes are exhibited at **MD/120 – INQ000129994**.

272. On 17 November 2021, I had updated the other nations at a CDL call that the Covid Pass implementation had been a success in Wales and consideration was being given to roll the system out more widely, with large hospitality indicating a preference for extension to them prior to Christmas. I raised a concern at that meeting that boosters were being included in the Covid pass for English citizens only, thereby disadvantaging people from Wales. We had been raising the need for Welsh data to be included since August. On the call, UK Government officials responded to confirm that there were no plans for its inclusion, although the note of the call (exhibited at **MD/121 – INQ000216596**) indicates this was followed up by an e-mail correcting that position.

273. On that call, the then First Minister for Scotland confirmed that they were considering the possible extension of the Covid Pass, whilst the then First Minister for Northern Ireland confirmed that there had been a recent successful Executive vote to introduce mandatory Covid Passes to the hospitality industry, irrespective of the size of the venue.

274. The further paper requested at Cabinet was provided on 17 November 2021, exhibited at **MD/122 – INQ000492869**, and Cabinet discussions returned to this issue on 25 November 2021, the minutes of which are exhibited at **MD/123 – INQ000057942**. Cabinet continued to discuss the public health considerations and

the need to ensure that any response was proportionate. It was further noted that, despite earlier signals to the contrary, the Scottish Government had decided not to extend the use of its vaccine passport. Cabinet Ministers concluded that there should be no extension to the use of the Covid Pass at this stage, although sought to ensure that the narrative announcing this decision did not constitute a relaxation of the rules.

275. On 27 November 2021, I released a Written Statement confirming that booster vaccinations would be added to the digital NHS Covid Pass for overseas travel purpose but confirmed that the domestic NHS Covid Pass requirements necessitated only the first and second doses for 'full vaccination' status. This is exhibited at **MD/124 – INQ000492861.**

276. On 6 December 2021, and in recognition of the high level of uncertainty surrounding the Omicron variant, Cabinet agreed to amend guidance so as actively to promote the use of lateral flow tests within 24 hours (rather than the previous 48 hours) for all circumstances where a person would be mixing. Minutes are exhibited at **MD/125 – INQ000022559**.

277. On 8 December 2021, the UK Government announced that it was proposing to move to Plan B of their Winter Plan on 15 December 2021 and intended to introduce mandatory use of the Covid Pass, which required full vaccination or the provision of a negative lateral flow test for higher risk events and premises (which were similar to the list being utilised in Wales and Scotland). The UK Government had also confirmed that it intended to remove proof of natural immunity from the domestic version of the Pass in England. This announcement was made at 6.00pm and I had been informed that the move to Plan B was forthcoming in a CDL call that took place at 5.00pm that day. I exhibit a note of that meeting at **MD/126 – INQ000216613**.

278. On 9 December 2021, I received advice, exhibited at **MD/127 – INQ000176899,** seeking my agreement to take a similar approach in Wales, with the Chief Medical Officer having previously advised that natural immunity appeared to offer less protection from the Omicron variant. This would mean that individuals who had not been vaccinated would need to provide evidence of a

negative lateral flow test. It was noted that England would be making changes to its App and we had the option of continuing our efforts to align or operating a parallel system with different rules. Officials advised that we align our approach accordingly. I agreed to this advice later that day thereby removing natural immunity as a qualifying condition under the NHS Covid Pass scheme, as exhibited at **MD/128 – INQ000492862**. The following day, I published a Written Statement confirming this decision and its implementation date of 15 December 2021, exhibited at **MD/129 – INQ000023304**.

279. Consideration of the continued use of the NHS Covid Pass was kept under review by Cabinet during January 2022, as restrictions were gradually lifted. During consideration at the review on 17 January, Cabinet agreed in principle to include boosters in the definition of those considered 'fully vaccinated'. However, there remained a need for more detailed operational advice on application and enforcement. Minutes of this meeting are exhibited at **MD/130 – INQ000130013** and I was also asked to note this in advice provided to me on 19 January 2022, exhibited at **MD/131 – INQ000271810**.

280. In accordance with the decisions made at Cabinet during this period, I also published weekly Written Statements which confirmed that, as various venues re-opened, the Covid Pass would continue to be required for entry to larger outdoor events (4,000 people if unseated, 10,000 if seated), larger indoor events, nightclubs, cinemas, theatres and concert halls. These Statements were made on 14, 21 and 27 January 2022 and are exhibited at **MD/132 – INQ000023309**, **MD/133 – INQ000023310** and **MD/134 – INQ000023311** respectively.

281. Alongside the above, and on 26 January 2022, I was provided with advice and asked to agree a technical amendment to the Regulations to enable those who were unable to receive a vaccination or take a lateral flow test for medical reasons to enter premises and events where the NHS Covid Pass was required. This followed earlier advice provided to the Minister for Health and Social Services on the definition of medical exemptions, which led to agreement that this should align to that of the Joint Committee on Vaccination and Immunisation. I agreed to this amendment and exhibit the advice and agreement at **MD/135 – INQ000271811** and **MD/136 – INQ000492863** respectively.

282. At the 21-day review held on 7 February 2022, Cabinet noted the mandatory use of the NHS Covid Pass had been an important part of the Welsh Government's response to Covid-19 but agreed that it was no longer proportionate in view of the continuing improvement in the public health situation and adverse impact of Covid-19. Accordingly, it was agreed that the requirement for venues to restrict entry to those with such passes should be removed from 18 February 2022, which would permit organisers time to stand down resources, processes and infrastructure. Venues remained able to choose to use the Pass scheme on a voluntary basis as part of their risk assessment and reasonable measures. A copy of these minutes is exhibited at **MD/137 – INQ000130031**.

283. On 10 and 16 February 2022, I received advice seeking my agreement to various amendments to the Regulations to effect the decision of Cabinet. I agreed to these recommendations, which are exhibited at **MD/138 – INQ000198585** and **MD/139 – INQ000177048** respectively. I announced this decision by way of a Written Statement on 17 February 2022, exhibited at **MD/140 – INQ000023313**.

284. I am aware in April 2022 that then-Secretary of State for Health and Social Care, Sajid Javid, wrote to the Minister for Health and Social Services, Eluned Morgan, to request her agreement to the decommissioning and closure of the NHS Covid Pass system. I often had anxieties about the speed and scale of decommissioning decisions by the UK Government. Their tendency was to go too fast and too far, which I felt would leave the UK vulnerable should the need arise to revive such measures in the future. Whilst those issues may be more fundamental in relation to other aspects of the response, that background anxiety would also have been present in these matters. This was emphasised in the response from Eluned Morgan of 27 April 2022 when she sought reassurance that, in agreeing, the system should be reactivated if the Welsh Government considered it necessary to do so at any point in the future. I exhibit a copy of this letter at **MD/141 – INQ000496076**.

285. I am asked about my view upon the necessity, efficacy and ethics of the vaccine certification / passport scheme in Wales. As is clear from the chronology set out above, the necessity, efficacy and ethics of the scheme were particularly

important in our decision-making and the Cabinet discussions held considered these issues in great detail before decisions as to its implementation, expansion and removal were made. The distinction between the mandatory vaccine certificate scheme originally being proposed by the UK Government (before its postponement) and the NHS Covid Pass scheme introduced by the Welsh Government was particularly important insofar as the ethics and equity concerns of the scheme. It was important to ensure that introduction of any such scheme did not constitute as a barrier for those who had declined to be vaccinated on medical or other relevant grounds. By providing qualifying criteria that included not only full vaccination but also provision of a relevant test within 48 (or 24) hours, this went some way to mitigate any inequity that such a scheme focused solely on vaccination could produce.

286. Cabinet was also mindful throughout all its discussions of the need to consider necessity and proportionality of the scheme in light of the public health concerns as they were presenting at the time. The discussions regarding the imposition and expansion of the NHS Covid Pass were one of the more closely balanced in the topic of vaccinations. However, on a day-to-day level, the Welsh public were generally receptive to the introduction of the scheme. I particularly recall speaking with members of the public at a Welsh rugby match in the Autumn Internationals of 2021 where they informed me that having the knowledge that others attending the event had either been vaccinated or provided a recent negative Covid-19 test mattered. It gave many other attendees confidence and reduced the anxiety otherwise involved in returning to attending large scale events.

Part G: Vaccine safety

287. I note at the outset of this section that I did not have a formal role in the post-approval monitoring of the Covid-19 vaccines.

288. The safety of the vaccines was routinely reported on as part of the Joint Committee on Vaccination and Immunisation's advice upon which the Welsh Government relied (following consideration and ratification by the Minister for Health and Social Services) and such matters were closely monitored by

vaccination officials in the Welsh Government and tracked by the Chief Medical Officers of the four nations.

289. I would receive regular reports of any evidence of risks emerging and, where necessary, would request further information to enable me to properly understand the safety risks under consideration. For example, in mid-March 2021, I was made aware, following an e-mail chain into which my private office was copied, of concerns regarding a potential link between use of the Oxford AstraZeneca vaccine and incidents of blood-clotting. Having become aware of this, I requested that a briefing be prepared for me by the following day outlining the latest position. Such briefing was provided to me on 16 March 2021. I exhibit at **MD/142 – INQ000493716**, **MD/143 – INQ000492823** and **MD/144 – INQ000410142** the original e-mail chain, my request and the briefing received.

290. Such matters would also be discussed when they arose at the weekly vaccination update meetings. Continuing the above example, I exhibit at **MD/145 – INQ000495961** the documents and agenda ahead of the weekly meeting which took place on 17 March 2021, upon which the topic of safety concerns surrounding the Oxford AstraZeneca vaccine was raised for discussion.

291. I recall similarly being made aware, including by way of the Joint Committee on Vaccination and Immunisation's advice upon the vaccination of children, of the safety concerns surrounding the potential risk of myocarditis and pericarditis in July 2021. These concerns (and the Joint Committee's advice generally) were then discussed in our vaccine update meetings, such as in that held on 26 July 2021, to which exhibit **MD/146 – INQ000493721** refers. Once more, the purpose of my being aware of these matters was for information and discussion purposes only, with the Minister for Health and Social Services being responsible for making the decision as to whether the vaccination of children should proceed. I understand Eluned Morgan has detailed in her statement the consideration she took as to the potential safety concerns in making this decision.

292. As to how the knowledge of any such risks around vaccine safety and side effects fed into decision-making, I had the benefit (as did some others in the Welsh

Government) of having gone through the experience of issues surrounding vaccination safety following previous vaccination programmes.

293. During my tenure as Minister for Health and Social Services from 2013 to 2016, we addressed the vaccine safety concerns arising from the Pandemrix influenza vaccine which had been utilised in the treatment of a new H1N1 strain of flu in 2009. I specifically recall an association between the use of this vaccine and the development of narcolepsy had resulted in a small number of significantly adverse consequences for affected patients on a UK-wide basis.

294. Having seen a very benign form of intervention in that context, I was acutely aware of the need to ensure that vaccine safety concerns were monitored and taken seriously. The development of narcolepsy was awful for the small number of people it affected, along with having a substantial consequent financial impact. Accordingly, and during the deployment of the Covid-19 vaccination programme, I was keen to ensure that I was kept up to date on such matters as they arose.

295. It was important that people were able to make informed choices about the vaccine based on accurate and trusted information, especially as our knowledge of the vaccine developed and where new cohorts were included for vaccines – for example, children. The Welsh Government worked and continued to work with Public Health Wales and the NHS in Wales to ensure the safety of the vaccine and make that information available to the public.

296. The vaccination strategies published by the Welsh Government stressed the importance for the need for an informed decision. The updated vaccination strategy published in February 2022, attached as exhibit MD/147 - INQ000480058, directed that there was both factual and trusted information on the Public Health Wales website for children and parents to help inform their decisions. The strategy also included a link to the helpful FAQs about the vaccine and safety available on the Public Health Wales website. Statistical information, data and supply of stock of vaccines, advice from the Technical Advisory Cell was also available on the Welsh Government's website.

297. Ministerial statements were frequently issued where there were new developments and changes to the vaccination programme. For example, the then Minister for Health and Social Services issued a statement on 20 April 2021, exhibit **MD/148 – INQ000507385** refers, in which he addressed the Joint Committee on Vaccination and Immunisation's advice to women who were pregnant and confirmed that throughout the vaccination programme, people's safety would always come first by ensuring a close review of vaccine safety reports and via the independent regulator, the Medicines and Healthcare products Regulatory Agency.

298. Transparency was a fundamental part of our public messaging with the Joint Committee on Vaccination and Immunisation's advice and the Medicines and Healthcare products Regulatory Agency's advice being communicated and signposted to the public. This is evidenced in the statement issued by Vaughan Gething MS referred to in the paragraph above. I am asked to comment on whether both relative risk and absolute risk should have been referred to and the concepts explained in the context of our public messaging. As I explained in the public messaging section above, whilst there was a Ministerial voice, trusted clinical and medical voices ranging from the Chief Medical Officer (Wales), Public Health Wales, public health experts and Muslim Doctors Cymru were relied upon to signpost the relevant clinical advice on vaccinations (such as that from the Joint Committee on Vaccination and Immunisation), thereby clearly setting out the risks and benefits of being vaccinated. The key to the success of the public messaging was that it could be clearly understood by its audience and it was for those clinical voices to determine how best to communicate the risk of the vaccine.

Part H: Vaccine Damage Payment Scheme (VDPS)

299. The vaccine damage payments are a matter reserved to the UK Government by virtue of paragraph 153 of Schedule 7A of the Government of Wales Act 2006. It is not a matter on which I have an informed opinion.

Part I: Therapeutics

300. As indicated towards the outset of this statement, the Medicines and Healthcare products Regulatory Agency is the regulator for medicines, medical

devices and blood components for transfusion in the United Kingdom. This includes all relevant vaccines and therapeutics in respect of Covid-19. I refer the Inquiry once more to the comprehensive explanation on the structure of the NHS in Wales and the role and purpose of the relevant groups involved in matters relating to therapeutics in the Welsh Government therapeutics statement and the statement of Vaughan Gething MS, insofar as it sets out the full detail of the allocation of functions in relation to therapeutics.

301. Against this background, I confirm I was not involved with the development of new therapeutics, the repurposing of existing therapeutics to treat Covid-19 or with any decisions related to eligibility for therapeutics. On a general basis, I am aware that a UK-wide approach (reflecting the UK Government's reserved powers) was taken to such matters although, as the statements detail, this involved engagement with the Welsh Government at both an expert and official-level.

302. Any such Ministerial decisions as were required in respect of therapeutics would have been a matter for the Minister for Health and Social Services in position at the relevant time and have been referred to in their respective statements to the Inquiry.

303. To the extent that I am asked to provide my view upon whether sufficient action was taken, in Wales and the UK, to develop and make available non-vaccine prophylactics for Covid-19 to address the needs of immuno-suppressed and immuno-compromised people, I had and have no reason to conclude that the actions taken were not.

Part J: Lessons learned

304. At the outset of this statement, I set out my view that the vaccine roll-out in Wales was a success because of the extraordinary efforts and commitment of the people of Wales, those in the Health Services that worked tirelessly in administering the vaccines, those in the military that supported the initial roll-out and, not least, those who came forward to be vaccinated. This point merits restatement here. Wales was the first country in the world to receive supplies of the Covid-19 vaccine and, on 8 December 2021, became one of the first countries

in the world to begin the roll-out of the vaccine to the people of Wales. I consider the vaccine roll-out to have been one of the real success stories of the pandemic in Wales.

305. As a result of the pandemic vaccination programme, the Welsh Government established a vaccination transformation programme to look at the provision of vaccination services and to ensure arrangements were fit for the future. The programme led to the publication of the National Immunisation Framework for Wales, which I attach as exhibit **MD/149 – INQ000401577.** The framework is intended to enable exemplar delivery of vaccination and immunisation programmes in Wales, with both uptake and equity at the core.

306. A further lesson to be learned arises from the development of the vaccine happening more quickly than originally anticipated. From this, we learned that the regulatory regime was able to operate in a more agile way than it would otherwise do in more routine times. In a public health emergency, it proved possible to discharge all of the necessary regulatory responsibilities at a speed commensurate with the nature of the emergency. In any future pandemic, we should expect that to happen and plan for it to happen. We remained able and ready to roll out the vaccine when it was available as we were being kept up to date, but we learned that the system could move more quickly than had been expected to and we should learn from that.

307. In terms of vaccine supply and logistics, the approach taken in the pandemic worked very well on a four nations basis. This approach has been carried through in terms of the Covid-19 vaccine into a 'business as usual' context. Improvements in ways of working on other routine vaccine supply and procurement arrangements are also visible, with the work in relation to the Moderna Strategic Partnership being a specific example of close 'four nations' working. However, matters such as these operate at an official level rather than a ministerial one.

308. As to the key barriers and challenges experienced, there was nothing unique to Wales in these. Wales had some positive advantages. I have already referred above to the unified and planned health service in Wales, which meant that we could make important decisions centrally and every Health Board would

know the position very quickly and be able to take action and respond. This was an advantage in Wales.

309. The barriers we faced were implementation challenges and, as indicated, were not specific to Wales. Examples include having to make choices about what the limited workforce is asked to do. During the first winter period particularly, this was relevant. If we are asking GPs to deliver vaccines, that time is not available for them to do other things in the winter period that they might otherwise be able to do. This meant that there were choices and challenges in Wales in the same way that they presented in the other nations.

310. In common with the other nations, our progress was hampered by, and we had to learn to overcome, the challenges of disinformation, vaccine hesitancy and anti-vaccination campaigns. As a result of the development of social media and the instant accessibility of information or disinformation spread through various channels, these are global issues and challenges. As detailed in this statement, we also knew about some groups being harder to reach and some being more anxious about the vaccination process than others.

311. In Wales, there were some small, relatively niche policy decisions on our side that assisted. We continued our approach to homelessness throughout the pandemic that everyone should be rehoused as, once that policy ended, there was a section of the population that could be reached and, if they remained unvaccinated as a result, they would pose a greater risk generally, as well as miss protection for themselves.

312. As I have outlined above, one of our strengths in Wales was the receptiveness of the Welsh population to messaging that getting vaccinated was not only for their own protection, but for the protection of others.

313. We also learned, when dealing with barriers to vaccine hesitancy in particular populations, that deploying community champions and trusted voices from within those communities was amongst the most effective thing to do, and that this must be done at street level. Muslim Doctors Cymru were a fantastic help in addressing these challenges. Communities were able to see young people who were members of their own community, who held standing in those communities,

engaging and talking to people about issues of concern to them. That kind of approach will always, in my view, be far more persuasive than a leaflet or messaging from the Government. Addressing these challenges in particular led to an increased level of granularity in addressing individual communities and specific places. I consider these experiences provide us with an important lesson to learn for any future pandemic situation.

314. As to whether lessons can be learned to reduce inequities in the deployment and uptake of vaccines in a future pandemic, I consider that the greatest contribution to tackle inequities will be to persuade people to take part or engage in routine vaccination programmes. Those who have taken part in routine vaccination programmes are more likely to take part in innovative vaccination programmes. We need to continue to invest in persuading people to take up vaccinations generally in order that they will be predisposed to take them up in a pandemic-type situation. As set out above, the pandemic has resulted in the establishment of the vaccination transformation programme, which will assist in working towards this.

315. As to whether there are any lessons to be drawn from differing approaches between the four nations, there was a degree of synergy in the deployment of the vaccine as a result of the four nations committing to follow, or being bound by, the Joint Committee on Vaccination and Immunisation's advice.

316. The only key area of distinction is the issue of requiring vaccination as a condition of deployment for health and social care workers. In Wales, we considered this to be counterproductive because we were successfully vaccinating large sections of our population and mandating vaccination could have undermined that. There were also moral and ethical considerations which again dissuaded us in pursuing this option. I consider we were correct to reject that policy in the Welsh context.

317. The take-up of vaccinations was linked to the levels of trust, which were reported as high in the Welsh Government. Where populations lose faith in government, that can have an impact on vaccination programmes. In Wales, we aimed for high trust and I consider that this fed into the success of the programme.

However, this is not true of all sectors of the population in Wales as there remain some communities where Government communication can be seen as something to cause concern. Those communities are better reached in the ways already set out at length above from within the community itself.

318. I have been asked to consider the balance struck between investment and development in vaccines and investment and development in therapeutics. As development is not a devolved matter, I cannot offer an informed opinion on this.

319. I have also reflected on the innovative approaches to the delivery of the vaccine deployment programme during the pandemic. We had not previously used members of the Armed Forces to deliver a vaccination programme, and so this was an entirely innovative approach. It was one undertaken out of necessity as there were not enough people who usually vaccinate to meet the urgency of the need. However, this turned out to be a very reassuring approach, particularly for elderly people. Whilst we did not initially undertake this approach for that reason, it was an added benefit of doing so.

320. Another innovative approach was the balance struck between planned and unplanned vaccinations. For the most part, reliance was placed upon planned appointments. However, we also used walk-up sessions later in the day to make sure that we used all of the vaccines available, particularly when we were working with vaccines with a limited shelf life. Striking this balance allowed us to maximise the impact of vaccine supply that would otherwise have been wasted. I consider this was an early, successful innovation.

321. Finally, we also utilised alternative venues from those traditionally used for vaccination delivery. These included community venues and sites that were already familiar to people, along with sites that had increased accessibility and basic amenities like free parking or drive-through vaccination centres.

322. All of these approaches contributed positively to what was ultimately a successful roll-out in Wales of the Covid-19 vaccination programme, in respect of which we have already implemented lessons learned in the transformation of our vaccination programme moving forward.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

Personal Data

Mark Drakeford MS

Dated: 10 October 2024